STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MT
APPLICATION YEAR: 2006

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The State of Montana maintains on file in its Fiscal Division all the assurance required by this application for Maternal an Child Health Block Grant. On file in agency rules are prohibitions of necessary items. The agency assures the MCHBG that the funds will be used for non-contruction programs, that debarment and suspension remain in place as in previous years, that the agency is a drug free work place and tobacco free. The agency has on file all necessary paperwork for lobbying state legislature and the prevention of fraudulent use of fund.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public input is solicited through local public health departments in the form of pre-contract surveys. Counties are also required to include consumer surveys in their contract responsibilities, to further inform them regarding the impact of MCH programs. Administrative Rules of Montana requires counties to conduct periodic needs assessments, which are reported via the pre-contract surveys.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council members, who represent various MCH partners and constituents. Updates on the needs assessment process were provided to the FCHB AC at each meeting during the last year, and the needs assessment and the priorities were sent to the AC for review and comment prior to finalizing. Advisory Council members will be invited invited to participate in the video link to the block grant review. A report on review findings is scheduled for August, and a copy of the final reviews are sent to the AC following receipt.

Copies of the block grant are made available to Advisory Council members, and availability of the text and data and updates on the block grant are provided through the FCHB Facts newsletter. The newsletter is distributed electronically every other month, and has a distribution of approximately 180 (in department) and 100 (out of department). A copy of a recent FCHB Facts newsletter is attached.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Montana's geography, population size and distribution, nature of her minority groups, political jurisdictions, and economic characteristics have a profound effect on: the health of her citizens; how direct and public health services are provided; and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives, and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and seven Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and state parks and state forests. The eastern two-thirds of the state is semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in June 2005. The laws they rated were seat belt use, young driver licensing, DUI, child restraint use, motorcycle helmet use, and red light camera laws. Montana had the poorest ratings for motorcycle helmet use and red light camera laws, with only marginal ratings for young driver licensing, safety belt use, and child restraint use. Montana was the third highest state for motor vehicle deaths per 100,000 people in 2003, accounting for 262 deaths. For 2004, Montana ranked 50th in the nation for motor vehicle fatalities with 2.5 deaths per 100,000,000 miles driven.

POPULATION CHARACTERISTICS: U.S. Census reports the 2000 population was 902,195, 44th in terms of population, with a population density of 6.2 people per square mile. The 2004 population estimates for Montana suggest an overall increase of 2.7% from 2000, with the in-state population redistributing to the western portion of the state and into urban areas. Montana has three metropolitan areas and five areas with a population over 10,000 people. Sixty-four percent of Montanans reside in these eight areas, with the remainder of the population dispersed into smaller communities, farms, and ranches. In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2004. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Projected population for 2030 is 1,044,898, ranking 27th in the nation for population growth.

The median age in Montana for 2000 was 37.5 years, higher than the national average of 35.3 years. Projections for 2030 suggest Montana's median age will increase to 46.0 years, representing a 22.7% increase in median age for the state. Montanans over 62 years of age are predicted to increase 115.6% by the year 2030, with a 0.4% decrease in children less than 18 years of age. Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprised 20.5% of the state population, and children and youth under 20 represented 28.5% of the population.

In 2002-2003, Montana pupils scored at or above proficiency for math, science, and reading assessments. Montana ranked 28th in math proficiency and 9th in reading proficiency, according to CFED for 2004. Montanans also tested slightly higher than the national average on the ACT, with 81% of graduating seniors taking the test. For 2003-2004, Montana had a high school diploma rate of 82.9% and a high school completion rate of 84.8%. Historically, Montana's pupil teacher ratio has been significantly smaller at 14.5 pupils per teacher than the U.S. average of 15.9. IEP percentages (learning disabilities) were slightly higher than the national average during the time interval. For 2003-2004, Montana ranked 47th in teacher salaries ($37,184), and state budget allocations for education were significantly lower than the national average (12% difference). People in Montana 25 years old

and over with a bachelor's degree or more in 2003 accounted for 24.9% of the population, ranking 27th in the nation. Estimates for 2004 suggest a 2.4% increase from 2003. Montana's university system comprises of two universities, four colleges, and five colleges of technology. In addition, there are six private colleges, seven tribal colleges, and three community colleges. Montana ranked 22nd in the nation for computer and internet presence in the home.

In 2002, Montana ranked 34th in total crime per 10,000, 29th in violent crimes, and 24th in the juvenile crime index. In 2002, Montana ranked 31st in percent of births to unwed mothers. There were approximately 13.6 TANF recipients per 1,000 population in April 2005, 87.7 food stamp recipients per 1,000 population, with the average amount of food stamps per household equal to $215.44. Both the number of cases and the average amount per case has increased steadily since 2000, according to DPHHS.

Montana is predominately white with approximately 91% of the 2000 population reporting Caucasian as the primary race, compared to 75% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.2% of the total population (56,068), the 5th highest state in the nation. Estimates for 2003 suggest a 4.8% increase from 2000, with American Indian births accounting for approximately 12.2% of the births in the state. The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, demonstrating a 5% increase from 2000 to 2003 (estimate). Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites. There are also isolated pockets of other minority groups including a Southeast Asian cluster of about 200 to 300 persons in western Montana as well as about 300 Russians.

2000 Census Population Demographics
White 90.6% Asian 0.5%
American Indian 6.2% Black 0.1%
Hispanic 2.0% Other 0.7%

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2004-2005, Montana had 15 Federal Super Fund sites and 208 CERCA priority facilities. The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana DPHHS has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the EPA in 2005, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. DPHHS Environmental Public Health Tracking was established in 2004 with support from a 3-year grant from the CDC. EPHT's vision is to better protect communities from adverse health effects through the integration of public health and environmental information, such as the Libby, Montana exposure. EPHT will improve surveillance of chronic diseases, birth defects, and developmental delays, and link health data with existing data on environmental hazards and exposures, to better inform the public regarding health concerns.

Montana also ranked 50th for employment wages, with the average annual pay equal to $26,001 for 2002 and 2003 estimates increasing only 3.3%. In 2001, at least 9.3% of employed individuals in Montana held more than one job. In December, 2004, the top five employment industries in the state were government, trade, transportation and utilities, education and health services, leisure and hospitality, and professional and business services. Tourism is becoming a major industry -- non-state residents spent $2.7 billion in the state in 2002. Approximately 9.8 million visitors generated 43,300 Montana jobs. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

Federal aid to state and local governments per capita for 2003 ranked Montana 12th in the nation. Federal funds accounted for 62 cents of every dollar of state revenues spent. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCH Bureau or the CSHS section is from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. Data for 2002 suggests Montana had $6,973,894 in federal funds and grants.

POVERTY: Montana is ranked 11th in the country for percent of the population below poverty level for 2000-2002. According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 live in poverty. Overall, 14.0% of Montana's population lives in poverty, while the national average for 2000-2002 was 11.7%. Preliminary 2003-2004 data suggests Montana has 20.2% of it's children living in poverty, ranking the state 42nd in the nation. Five out of seven reservations are found in eastern Montana, an area with limited natural resources, high unemployment, and disproportionate poverty.Since 2001, Montana's unemployement rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to the U.S. rate of 5.5%. However, unemployment for the tribes ranged from 40.58% to 77.21%, with an average unemployment rate of 59.63% for 2001 Montana Progressive Labor Caucus data. Reservation data collected by Montana DLI suggests lower unemployment rates may exist. Year after year, data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

Annual Average Unemployment Rates on Montana's Reservations

Reservations	2001 % Employed	but Tribes 2001 below poverty
Blackfeet	70.0%	26.0% 69.93%
Crow	66.0%	16.0% 60.65%
Flathead	76.0%	22.0% 40.58%
Fort Belknap	71.0%	20.0% 70.49%
Fort Peck	63.0%	23.0% 62.54%
Northern Cheyenne	27.0%	7.0% 64.69%
Rocky Boy's	36.0%	37.0% 77.21%
Reservations Total	59.86%	NA 59.63%

In 2004, Montana ranked 20th in bankruptcy filings by individuals and businesses. Homeownership rates for 2004 data suggest 71.5% of Montanans own their home, ranking 23rd in the nation.

POLITICAL JURISDICTIONS: The state has 46 frontier counties, 8 rural counties, and only 2 urban counties. Fifty-four county health departments contract with the DPHHS to provide MCH and other health services, but the local health departments are county entities under the control of local Boards of Health, and the staff are county employees. The seven Indian reservations have nation status for 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems. The other three tribal health clinics belong to the three "compact" tribes that staff their own clinics. Although the I.H.S. data system is used at all seven tribal health clinics, patient health data that is not entered into the system for I.H.S. staff services may not be shared with the State without separate agreements with the three compact tribes. According to the Tax Foundation, the federal tax burden on Montana is 17.5% for 2005, ranking Montana 35th in the nation. The state and local tax burden is 9.5% for 2005, ranking the state 39th in the nation. New tax relief measures implemented in 2005, including a 10% tax bracket, child tax credits, reduction of income tax rates, and reduction of the marriage penalty, will provide benefits to thousands of taxpayers and businesses. Child tax credits, reduction of income tax rates, reduction of the marriage penalty, and other changes to the tax laws will benefit many Montanans.

ACCESS TO HEALTH CARE: Nine counties have no private medical services at all. There are 54

local county public health departments. Health care for the tribal residents of Montana is provided by a network of services including: off-reservation hospitals; clinics and practitioners; county health departments; Indian Health Service systems; and tribal health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte. Montana ranked 15th in the nation for the percent of health dollars for public health, 19th in per capita public health spending, and 36th in adequacy of prenatal care. Montana has 21 local hospitals, 40 Critical Access Hospitals (CAHs), and 20 Community Health Centers. All hospitals provide access to care for low-income, indigent, Medicaid, and Medicare patients. There are two hospitals that provide pediatric mental health care, five provide care exclusively for veterans and American Indians and are federally owned and operated. All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Sixty percent of primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark, and Flathead counties, the seven most populated counties in Montana. Establishment of Rural Health Clinics (RHC), under the provisions of PL. 95-210, has improved access to health care in many counties and communities. There are 40 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. There is one Migrant Health Center (MHC) in Montana located administratively in Billings. Satellite services have been provided over the last several years in six locations.

According to 2004 CFES data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums.

Oral health care had become a major public health issue. The Montana Foundation of Dentistry for the Handicapped provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly, and who cannot afford dental care. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services, though the waiting lists can be long. Dental clinics are offered in thirteen locations through the Indian Health Service. Montana's point-in-time PRAMS in 2002 reiterated lack of access to dental care for pregnant Medicaid participants was a statewide problem. Data for 2004 suggests Medicaid-payable dentists are also a resource problem, with 14 counties lacking at least one Medicaid-payable dentist and 14 counties with only one Medicaid-payable dentist, representing 50% of all Montana counties. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

High mortality rates are a large problem for Montana. Montana ranks 46th in the nation for occupational fatalities, with 12.3 deaths per 100,000 workers for 2004. Cardiovascular deaths for 2004 equaled 296.2 per 100,000 people, ranking 11th in the nation. Cancer deaths in Montana ranked 23rd in the nation, infant mortality 27th in the nation, premature death 22nd in the nation, and total mortality 32nd in the nation. Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, diabetes, pneumonia, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Indians, accidents, diabetes, and chronic liver disease and cirrhosis follow heart disease and cancer for the leading causes of death. Whites typically die at an older age than Indians. (Montana Bureau of Records and Statistics, 2003) Montana is 2nd in the nation for death rate by suicide, at 19.3 per 100,000 population in 2001.

Drug abuse in Montana is a growing concern, especially methamphetamine use. The U.S. Drug Enforcement Administration reported 2003 federal drug seizures in Montana included 0.5 kg cocaine,

107.2 marijuana, and 8.8 kg of methamphetamine. In 2002, Montana law enforcement agencies responded to 122 meth labs statewide. BRFSS for 2003 reported 9.3% of students grades nine to 12 reported using meth at least once in their lives. The Billings area has an active methamphetamine task force while other communities scramble to become informed about the implications of meth use and the potential impact on the maternal and child populations in their areas.

Domestic violence continues to grow in scope. Statistics for 2001 suggest 7.0% of aggravated assaults were by a spouse or ex-spouse and 6.5% were from boyfriends or girlfriends. PRAMS data for 2002 suggests 8.8% of all Montana women aged 15-45 are abused before pregnancy and 5.0% during pregnancy. However, the Montana Board of Crime Control suggests reported domestic violence to be only 0.45% of the population-at-risk for abuse, suggesting underreporting is a serious issue in Montana.

CDC's State Health Profile for Montana notes childhood health concerns include birth defects, vaccination coverage, infant mortality, prenatal care, and teen pregnancy. Montana has developed a birth defects registry that now contains data for 2000 through 2004. A heightened rate of Downs Syndrome appears in the data, along with other defects of concern including gastroschisis, diaphragmatic hernia, and cardiovascular defects. The Fetal Infant Child Mortality Review (FICMR) program, authorized by the Montana State Legislature in 1997, has published two reports since its inception. There were 1,256 fetal, infant, and child deaths in Montana from 1997-2002, accounting for 1.0% of the cumulative birth cohort (N=130,694). Cumulative review percentages suggest 59.2% of all fetal, infant, and child deaths were reviewed by the 27 local FICMR teams covering 48% of the counties. Nevertheless, the program determined that 39.7% of the cumulative reviewed deaths that contained prevention findings were preventable.

Montana continues to face a health care worker shortage. During the reporting years 2001 to 2002, a task force was created and appointed by the Governor "to accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." As of 2002, there were 2.0 physicians per 1,000 population, as compared to the U.S. average of 2.3 physicians per 1,000 population, according to the Northwest Area Foundation. This statistic ranks Montana approximately 34th in the nation. For the year 2012, DLI predicts only 2,077 physicians and surgeons for Montana, a rate of 2.1 physicians per 100,000 population, based on a 984,043 population projection. Dieticians and nutritionists are projected to reach 216, a rate of 2.2 per 100,000 population. Registered nurses are projected to reach 10,707, a rate of 10.9 per 10,000 population. However, even with all the known shortages, Montana's response has only been to establish a task force commission or panel, which is 1 out of 7 measurable responses.

In 2002, Montana ranked 44th and 47th in the nation for series of immunizations given to 19-35 month old children. In 2003, Montana ranked 24th in infant mortality at 6.8/1000 live births. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. In 2002, Montana estimates indicated 54% of the adult population to be overweight or obese. The same dataset estimated the adult smoking prevalence rate to be 19.9% of the population. Smoking-attributable direct medical expenditures (state share) are estimated at $216 million. There are approximately 1,439 annual smoking-attributable deaths in Montana, according to the Center for Tobacco Cessation. Montana is 1st in the nation for adolescent male use of smokeless tobacco. In 2000, Montana ranked 35th in Medicaid recipients and 25th in state and local funding spent on health and hospitals. Montana ranked 34th in per capita spending on Medicaid recipients, 7th in average Medicaid spending per child, and 19th in Medicaid spending on aged recipients. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in HMOs in 2003, down from 2002.

This snapshot does not tell the whole story. Montana needs nearly 1,000 more health care workers right now just to catch up to the national averages! And, as Montana's population continues to age, demand for all occupations - including those that are now adequately staffed - will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of our older-than-average population

B. AGENCY CAPACITY

The Title V programs are located within the Health Resources and Public Health and Safety Divisions of the Department of Public Health and Human Services. The structure of DPHHS is described in the organizational structure section of this application. Title V efforts are primarily focused in the Family and Community Health Bureau of the Public Health and Safety Division (PHSD) and in the Children's Special Health Services (CSHS) program, which is located in the Health Care Resources Bureau of the Health Resource Division.

The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Family and Community Health Bureau has a staff of approximately 30, and a budget of approximately $21 million, from 13 funding sources including grants from CDC, HRSA, SAMHSA, USDA, the Office of Population Affairs, and Montana general fund. The largest program and budget is the WIC Program, with a budget of approximately $14 million. The MCHBG is the second largest funding source, at about $2.5 million annually. Approximately 95% of the FCHB budget is federal dollars.

Local providers are crucial partners in the provision of MCH services in Montana. Approximately 42% of the MCHBG is contracted out to local health departments to provide MCH services to the population. Of the $1.1 million of state level match, 1/2 of that is also contracted to local health departments for public health home visiting services to pregnant women and infants. The remaining $500,000+ is contracted to for genetics services for the MCH population.

FCHB is also responsible for coordinating the MCH needs assessment and subsequent further prioritization of MCH needs and strategic planning that will take place in 2005 and 2006.

The Children's Special Health Services (CSHS) program in the Health Care Resources Bureau administers 30% of the MCHBG. HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include cleft cranio-facial clinics, metabolic clinics and case management services, regional clinics, nutrition services, neonatal follow-up, newborn screening follow-up, medical home program, transition services, case management, care coordination, clinic coordination, systems of care development, dental services, vision services, hearing aids, medical services, enrollment, and medical reviews.

Indirect services to children include: outreach, cultural competence, plan relations, provider relations, advocate liaison, enrollee education/newsletter, quality assurance/improvement, customer service, family support and referral, health care integration for access, coordination and referral, policy development and review, complaint processes, web page development and maintenance, and data systems development and coordination.

Administrative services include: office and facilities management, personnel management, labor-management relations, state/federal coordination, CHIP State Plan, MCH Block Grant submission, administrative rules, file and chart systems, research, professional development, surveys, technical assistance, contracts, waivers, payroll, new employee orientation, communication, budget and fiscal, performance measurement, grant writing, safety and security, program evaluation, legislative support, congressional requests, public relations, and purchasing and inventory.

Co-location of the CSHCN program with the CHIP program has facilitated coordination of applications for services for children between those two programs, Medicaid, and other programs, which may benefit children and their families. The HCRB Bureau manages the Family Health Line, which is the Title V toll free line, directing callers to programs within DPHHS and around the state. The Children's Mental Health Bureau is also located in the HR Division. That bureau is directing development of the Kid's Mental Health Services Areas or KMA's in the state, which may address and improve the mental

health service needs of the MCH population.Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors.

Services include specialty clinic services, direct payment of medical services for eligible children who have no source of payment for needed care, identification and referral of children with special health care needs, and consultation and technical assistance. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. In Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. Montana does not have a medical school or a school of public health, and relies on partnerships with private providers to develop and deliver services to the vulnerable populations. The CSHS has developed partnerships with two hospitals in Missoula and Billings for regional specialty clinic services, and is working towards development of a third regional clinic site in Great Falls. The Montana Legislature included a line item to support additional regional clinic development in the 2005 session. Program staff is developing the ability of clinics to bill for services, which will diversify funding available to support these sites, which have been primarily supported by hospital in-kind and MCHBG contract funds to date.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Parents Lets Unite for Kids (PLUK) is a longstanding advocate for parents and families, and the host organization for Montana's Family Voices chapter. Work with PLUK has centered on collaboration to improve access to community-based, family-centered services for CSHCN.

The Family and Community Health Bureau's mission is the "promote the health and well being of Montana's citizens to help healthy families build health communities." The bureau is organized into four sections: the MCH Data Monitoring (MCHDM) section, the Child, Adolescent and Community Health (CACH) Section, the Nutrition/WIC Section and the Women's and Men's Health Section. MCHBG funding and program efforts are primarily located in the MCHDM and CACH sections.

The MCHDM section manages the 54 local MCH services contracts, oversees the MCH block grant development and performance measure monitoring, and is responsible for the population based newborn metabolic and hearing screening programs. That section has also housed the Point in Time Pregnancy Risk Assessment Monitoring project from 2001 -- 2004; the state intends to apply for CDC funding to reinitiate the program in 2005. The MCHDM section also manages the state's genetics program and contract, which is funded with a tax on individual insurance policies. Legislative changes in 2005 resulted in an increase of that funding source, which will in turn result in a reassessment of contractor role and services.

The MCHDM section houses Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), which was initiated with CDC funding in 2000. The population-based registry identifies and refers children in need of services to the CSHCN and other appropriate services. Initially, the program was a passive case ascertainment system, focusing on four major anomalies - congenital hypothyroidism and cleft-craniofacial, cardiac, and neural tube defects. CDC recommended active case ascertainment, which was added in 2001. The program was funded for an additional three years of CDC funding in 2002. A renewal application submitted in early 2005 was reviewed, approved, but not funded, leaving the future of the registry in question. At present, the registry, including the active case ascertainment will be continued with carry over dollars, supplemented as possible with MCHBG. The long-range feasibility of continuing this support continues to be in question, especially in view of the MCHBG decreases over the last several years. Birth defect monitoring efforts continue with grant carryover and MCHBG funding at this time -- partnerships with the state's Environmental Public Health Tracking program are being explored. The registry has helped identify and inform investigations of what appeared to be high instances of Down Syndrome and gastroschisis in Montana over the last several years. The gastroschisis investigation continues with the help of student efforts from the Rollins School of Public Health at Emory University.

Montana's "heelstick" newborn screening follow up has been housed in the FCHB since 1995 and is a part of the MCHDM section. Follow up efforts continue to be a partnership between medical providers

and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana presently screens for four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Interest in adding additional tests has been expressed by the medical community, but in light of fiscal constraints and resistance to increases in existing lab charges, no additional lab screenings have been mandated in the last few years. Montana is monitoring national efforts to recommend additional screening tests in the future. At present, our state lab, which conducts newborn screening for the state, lacks mass spectrometry equipment, which will be necessary for inclusion of some of the additional tests. The lab presently works with out of state labs to facilitate provider requests for additional testing.

Newborn hearing screening is also coordinated by the MCHDM section, in conjunction with the metabolic screening program and the birth defect registry. Montana has increased capacity for newborn hearing screening in the state, moving from approximately 30% of newborns tests 4 years ago to more than 80% at present. The state and the advisory group for this program now face the difficult task of how to facilitate screening in the very small communities where limited resources for testing and follow up exist, and to assure effective follow up, especially in small communities. The group will be examining various approaches to this challenge in FFY 2006.

The MCHDM has been the lead player in development of standardized reporting capacity for local public health, concentrating on MCHBG and PHHV reporting requirements. The Integrated Data for Evaluation and Assessment (IDEA) Project was designed in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. The Public Health Data System (PHDS) was developed for use at local health departments to support their client case management and reporting capability. PHDS has been designed to support four of the public health programs provided at the local level -- client case management and tracking, an initiative to serve women with high risk pregnancies, family planning and immunizations. The immunization component will include: population of the immunization registry with birth record data; immunization data from the Indian Health Service and participating tribal health departments; and linkage with private providers of immunizations. Interface of the PHDS with the Indian Health Service data system in use in Montana's tribal health department stalled when the IHS decided to establish its own national immunization registry interface protocol for use by all states. The PHDS has been rolled out to 83% of the local public health departments, and plans to convert the web based structure with increased ease of data entry is presently in process.

In 1985, the Montana legislature authorized the creation of a voluntary statewide genetics program, funded by a tax on individual insurance policies. The program provides for newborn heelstick screening follow up, and genetic services and education for the people of Montana. FCHB provides the newborn screening program follow up, referring children identified with metabolic disorders to the CSHCN and genetics programs for intervention and evaluation. In 2004, a formal request for proposal (RFP) process was undertaken to award a new contract for clinical genetic services for Montana after more than a decade of annual renewal of the existing contract. A new contract has been awarded to the previous contractor and services and reporting requirements have become more clearly focused. The 2005 Legislature considered and passed a bill increasing the tax on individual insurances, which provides the funding to support the program. This increase sunsets in 2007, requiring the department to investigate alternative mechanism to fund the programs, with a goal of increasing the base upon which the funding depends.

The Child, Adolescent and Community Health Section houses many of the staff and programs most directly impacting the MCH population. Staff in the section manage and monitor the public health home visiting program for pregnant women and infants, the fetal infant child mortality review, the SIDS prevention, fetal alcohol prevention and youth suicide prevention programs, the early childhood comprehensive systems project, the oral health program, and provides consultation on general child, school and adolescent health issues.

The public health home visiting (PHHV) program has a long history in the state. In 1989, the Montana

Legislature enacted legislation establishing the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) and supporting it with general funds. The goals of the legislation compliment the charges in Title V of the Social Security Act, which are to 1) assure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services, 2) reduce the incidence of infant mortality and the number of low birth weight babies and 3) to prevent of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. The program has continued to evolve, with efforts in 2004 targeting focusing the program on pregnant women and infants, and emphasizing home visiting as the preferred mechanism of providing services. At present, there are 19 contractors for PHHV services, including three tribal programs.

Montana's oral health program is also located in the CACH Section. The oral health program focuses on population based and infrastructure services to develop community awareness of the importance of oral health and to build capacity at the state and community levels. The program has benefited from the State Oral Health Collaborative Systems grant program, which has facilitated focus on system development. The oral health program coordinator has worked with the Primary Care Office and Primary Care Association over the last several years to focus education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The oral health program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs, and works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the pre-school population. Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).

The CACH section also supports efforts to prevent Fetal Alcohol Syndrome and Effect through prenatal prevention efforts. This effort was first supported by Congressional set-aside funding focusing on South Dakota, North Dakota, Minnesota and Montana. The project funded $3 million dollars per year to develop a three component effort which included 1) the creation of a Four State FAS Consortium, charged with program development, implementation and evaluation, 2) assessment which included gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region and 3) intervention projects, focused on the prevention of fetal alcohol syndrome and fetal alcohol effect. Montana's intervention was built upon the PHHV/ MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project also enabled collaborative efforts to support FAS evaluation clinics in the state. Funding for the four-state consortium was no longer earmarked in 2004, and the staff applied for and received a Fetal Alcohol Syndrome Centers for Excellence award from SAMHSA in 2004.

The Fetal Infant and Child Mortality Review (FICMR) program directs and guides local efforts to review deaths of fetuses, infants and children 18 years of age or younger. The purpose of the review is to enable communities to identify risks or challenges in their communities and to implement appropriate prevention measures. State level functions are to compile and examine data looking for patterns and clues indicating statewide and/or legislative policy changes required. Examples of the uses of FICMR data include testimony to the 2005 Montana legislature regarding the importance and need for a graduated driver's license for young drivers, primary seat belt laws for children, and standardized medication administration policy in day care settings. The data was lauded by MCH advocates as useful and supportive of preventive efforts for the MCH population.

SIDS prevention is an ongoing effort in Montana, as in other states. A recent innovation has been the availability of a "Safe Sleep" program, providing safe cribs to needy families across the state. Public Health Nurses in counties and tribal settings may request cribs on behalf of clients who require a safe sleep environment for an infant. Requests for cribs are processed through public health nurses, and the cribs are then ordered and delivered to the public health nurse for delivery to the client. The added benefit of PHN contact and education regarding a safe sleep environment and other preventive information has been a major selling point for the program. Support for the program has been

received by the Montana Healthy Mothers, Healthy Babies Coalition, private foundations and the Emergency Medical Services for Children Program.

CACH also provides technical assistance and consultation to local public health and school staff on matters impacting child, adolescent and school health. Efforts to continue general support and development of preventive and supportive Adolescent Health Efforts to develop strong adolescent health services continue with emphasis on the two top causes of morbidity and mortality in Montana: unintentional injury and suicide.

Suicide has, and continues to be recognized in Montana as a major public health concern. The department worked in conjunction with mental health provider, advocates, local partners and others to develop the first Suicide Prevention Plan, which was finalized in 2001. Funding was also obtained from the Governor's office in 2004, and from Preventive Health Block Grant carryover in 2005 to conduct an assessment of resources for suicide prevention in the state, and to support local efforts to prevent youth suicide. A report of the status of effort is attached to this document. DPHHS partnered with others to submit an application for a SAMHSA Cooperative Agreement to address youth suicide in June of 2005.

The Family Planning program receives a small amount ($25,000) of MCHBG funding which it includes in the contracts with 15 local agencies to provide family planning services in 38 locations. Family planning programs are designated STD programs and all programs have enrolled medical service providers that provide comprehensive breast and cervical screening services to an identified target population. The family planning program serves approximately 28,000 men and women annually, including adolescents. The program helps to decrease the incidence of unintended pregnancies and births to teen mothers, which are MCHBG performance measures.

Statutory Authority for Maternal and Child Health Services Authority for maternal and child health activities within the Department are found in the Montana Codes Annotated (MCA 50-1-2020. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); accept and expend federal funds available for public health services, and use local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Title 16, Chapter 24, and sections 901 through 1001 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including crippled children, family planning and school health. A 1996 addition to the Rules describes the Standards for Receipt of Funds for Maternal and Child Health Block Grant. Newborn screening is required through ARM 16.24.201 through 215. MCH 50-19-301 through 323 authorized and describes the MIAMI project. Administrative rules describing and authorizing case management for high-risk pregnant women are contained in ARM 46.12.1901 through 1925.

C. ORGANIZATIONAL STRUCTURE

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director, Robert Wynia, MD oversees the agency, its 3,000 employees and approximately 2,500 contracts and 350 major programs. DPHHS has a biennial budget of about $2 billion.

The Department of Public Health and Human Services (DPHHS) is a " mega agency" encompassing health and human services for the state of Montana. Statewide reorganization of health and human services agencies in 1995 created DPHHS by combining the Department of Social and Rehabilitation

Services, the Department of Family Services, and parts of the Department of Health and Environmental Services and the Department of Corrections. During the reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

The reorganization combined public health and Medicaid services into a single division, knowns as the Health Policy and Services Division. In 2003, that division was split to create the Health Resources Division and Public Health and Savety Division.

The DPHHS Director's Office includes staff and programs that support the attainment of the department goals and the divisions' efforts to implement programs. The department has one deputy director, John Chappius, who also functions as the state Medicaid director. Programs within the director's office are; the Prevention Resource Center; the Office of Planning, Coordination, and Analysis; the Office of Legal Affairs; the Human Resources Office; and the Public Information Office. The Department's four broad goals are:

All Montana children are healthy, safe and in permanent loving homes.
All Montanans have the tools and support to be as self-sufficient as possible.
All Montanans are injury free, healthy and have access to quality health care.
All Montanans can contribute to the above through community service.

DPHHS is organized into eleven divisions. They are:
Addictive and Mental Disorders Division;
Child and Family Services Division;
Child Support Enforcement Division;
Disability Services Division;
Fiscal Services Division ;
Health Resources Division;
Human & Community Services Division;
Operations and Technology Division;
Public Health and Safety Division;
Quality Assurance Division, and
Senior and Long Term Care Division.

The majority of state level activities and services to the maternal and child population take place within the Public Health and Safety Division (PHSD). The mission of PHSD is to "Improve and protect the health and safety of Montanans." Jane Smilie has been the administrator of the Division since January 2005. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The State's public health system is a complex, multi-faceted enterprise, requiring many independent entities to unite around the goal(s) of health improvement and disease prevention at the community-level. These entities include local City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The public health system is a part of the continuum of care available to the citizens of Montana and the PHSD promotes and supports both the availability and the quality of public health services available to Montanans. The Division is organized into six bureaus:

Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
Communicable Disease & Prevention Bureau - Bruce Deitle Acting Bureau Chief
Family and Community Health Bureau - JoAnn Dotson, Bureau Chief
Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
Laboratory Services Bureau - Anne Weber , Bureau Chief
Public Health Systems Improvement and Preparedness Bureau - Bob Moon, Bureau Chief

The Health Resources Division admisistrator is Chuck Hunter. The division brings together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental

Health Program. In addition to the children's services, the division houses the primary care and hospital portions of Medicaid. This division is organized into six bureaus:

Acute Services Bureau -- Duane Preshinger, Bureu Chief
Children's Mental Health Bureau -- Pete Surdock, Bureau Chief
Fiscal Services Bureau -- Beckie Beckert-Graham, Bureau Chief
Health Care Resources Bureau -- Jackie Forba, Acting Bureau Chief
Hospital and Clinical Services Bureau -- Brett Williams, Bureau Chief
Managed Care Bureau -- Mary Angela, Bureau Chief

Maternal and child health services as described in the Title V of the Social Security Act are the responsibilities of the Family and Community Health Bureau (FCHB) and the Health Care Resources Bureau (HRB).

The Family and Community Health Bureau has a staff of 30 and a total budget of approximately $21 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Maternal Child Health Data Monitoring -- position vacant
WIC/Nutrition -- Chris Fogelman, Supervisor
Women's and Men's Health -- Suzanne Nybo, Supervisor

The Health Care Resources Bureau (HCRB) has 18 staff members and an annual budget of approximately $16 million. The bureau is organized in two sections:

Children's Special Health Services (CSHS) -- BJ Archambault, Acting Supervisor
Children's Health Insurance Plan (CHIP) -- Jackie Forba, Supervisor.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.state.mt.us/aboutus/orgcharts/orgchart.shtml. Organizational charts for the Public Health and Safety Division, the Family and Community Health Bureau, and a combined Human Resources Division and the CHIP/CSHS Bureau are attached as a single document.

D. OTHER MCH CAPACITY

The MCHBG supports 10.69 FTE at the state level. These FTE are all or part of 16 staff members' time. The amount of FTE supported by MCHBG and the role of the staff member are described below:

Section Staff member FTE Role
Paid by
MCHBG
CACH
Dennis Cox 1 Adolescent/School Health
Deborah Henderson 0.5 CACH Section Supervisor
Wilda McGraw 1 FICMR, Child Health
Cindy Mitchell 0.5 Admin Support
Cheri Seed 0.5 Oral Health
Sandra Van Campen 0.5 PHHV/FAS Prevention

MCHDM
Sib Clack 0.35 NB Screening & Birth Defects

Kindra Elgen 0.50 MCH Data Manager
Rosina Everitte 0.17 MCH Epidemiology/Statistician
Jack Lowney, 1.00 MCHBG & Contracts
Subtotal of CACH and MCHDM 6.02

CSHS
Archambault, B. 1.00 Nurse Consultant and Acting Supervisor
Donnelly, M. 0.80 Nurse Consultant and Data System
Gruby, T. 0.87 Accountant
O'Donnell, M. 1.00 Clinic Coordinator
Scott, C. 1.00 Outreach Coordinator
Subtotal 4.67
Total 10.69

Jo Ann Dotson's time is cost allocated across the bureau based on staff time, incorporating some MCHBG based on 6.02 FTE. Jackie Forba's time is fully covered by CHIP.

The FCHB Bureau has a staff of 30 and the HRB a staff of 18. All other FCHB state staff and portions of the MCHBG supported staff are paid from other funding, including federal funds (WIC, Title X, Newborn Hearing Screening, SOHCS, SSDI and FAS) and a small portion of general fund. HRB staff outside of the CSHS program is supported by a combination of federal CHIP and state match.

FCHB has one federal staff person, Dianna Frick, who is responsible for coordinating the 2005 needs assessment and the subsequent MCH needs prioritization and strategic planning. Dianna's position will be in existence for two years (Sept. 2004-Sept. 2006) and is a result of FCHB's successful application for a Public Health Prevention Service fellow through the Centers for Disease Control and Prevention.

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated -- for SFY 04, that estimate is for approximately 5.3% of the total budget. In addition, state law allows local health departments to use up to 10% of their funds for administrative purposes. Local agencies have been reported approximately 7.2% of their expenses as administrative costs.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. MCHBG is distributed to 54 of the 56 counties through MCH Contracts. Those amounts are based on an allocation formula that considers target population and poverty levels. The amount of funding obviously impacts the amount of time and subsequent work,which may be "purchased" with the dollars -- some of the smallest counties receive only $1,000. The funding does require that a designated individual be available to monitor MCH needs. According to the Montana 2004 County Health Profiles, there were approximately 124 public health nurses, 84 registered sanitarians, 14 registered dieticians and 41 health educator FTEs in public health settings across the state. The MCHBG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Public Health Data System (PHDS) is a system developed for local health departments to use for case management and project reporting. SSDI funding helped in the initial development phases. The system is supported with approximately $25,000 annually -- to date that amount has been matched or exceeded by various other sources, including Preventive Health Block Grant, Immunizations and Title X. While still a work in progress, the concept of common reporting software is crucial to accurate assessment and documentation of public health services. Administration of the PHDS has been transferred to the Public Health Informatics Section in the Division.The Health Resources Bureau maintains a Family Health Line Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line with which Montanans can access information about health care programs for children and other health issues sponsored and

promoted by the Department. Most of the calls received on the Family Health Line are related to CHIP (the Children's Health Insurance Plan), but approximately one-fourth of the nearly 12,390 phone calls received in 2004 has a referral component, in which the caller is referred to programs, both public and private, including those administered under Montana's Maternal and Child Health Block Grant. The National March of Dimes Toll Free line now provides consumer and provider call in services, with back up teratogenic counseling and assessment available. Montana continues to support the concept of a nationally supported toll free line, similar to the Poison Control Line system created approximately 25 years ago.

Brief Bios for the Bureau Chiefs and Section Managers for the MCH and CSHS Areas are included below:

Jo Ann Walsh Dotson RN MSN, is Chief of the FCHB. Ms. Dotson is a pediatric nurse, with a Bachelor of Science in Nursing from Baylor University and a Master of Science in Nursing from University of Texas. Ms. Dotson practiced in specialty inpatient and public health settings in three states prior to moving to Montana. She was an assistant professor of nursing at Montana State University eight years, and has been at the state health department for 12 years, in various positions including nurse consultant, primary care officer and section supervisor for the Health Assessment and Resource Development section in the Health Systems Bureau. She has been the bureau chief for five years. She is presently a doctoral student at Oregon Health & Sciences University, recently completing her third year of course work. Ms. Dotson completed a three-year fellowship with the Robert Wood Johnson Executive Nurse Fellows Program in 2002. Ms. Dotson serves on a number of advisory councils in and out of state government, including the Montana Council on Developmental Disabilities, the board of directors for Montana's March of Dimes and is the Region VIII Councilor forthe Association of Maternal Child Health Programs.

Chris Fogelman, RD MPH, is the manager of the Nutrition Section, which includes the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Ms. Fogelman is a Registered Dietitian, with a Bachelor of Science in Home Economics with an Emphasis in Dietetics from Mount Marty College in Yankton, SD, traineeship at McKennan Hospital in Sioux Falls, SD and a Master of Public Health in Public Health Nutrition and Maternal Child Health from the University of Hawaii in Honolulu, HI. She has worked in the field of public health nutrition focusing on maternal and child nutrition for over twenty years. Ms. Fogelman has been in her present position for approximatelyThree years and with the WIC Program for twelve years. Ms. Fogelman currently serves as a board member-at-large for the Montana Dietetic Association and as a member of the Rocky Mountain Development Council Head Start Health Advisory Council.

Deborah Henderson, RN is manager of the child, Adolescent and Community Health Section. Ms. Henderson is a registered nurse, with a BSN from Jamestown College, Jamestown, ND. Ms. Henderson worked as a public health nurse for counties and HIS As well as a pediatric and nursery nurse before moving to Montana and took a job at the state health department in 1991. She has been in her current position for five years. Ms. Henderson has completed the MCH PHI certificate program.

Suzanne Nybo, MS, is Section Supervisor for the Women's and Men's Health Section. Ms. Nybo has a graduate degree in Psychology/Applied Science in Social Science from Montana State University. She administers and supervises a state reproductive/preventive health care program and is the Director of the federal Title X Family Planning Program and Co-Women's Health State Coordinator. Ms. Nybo has worked in reproductive and public health for 29 years and received numerous state and national awards for her leadership in reproductive health care. Ms. Nybo currently serves on the Public Health Improvement Task Force, on the safety net subcommittee of the State Health Plan advisory committee, and as the Bureau's Management Representative on the Employee Labor Management Committee. She and section team received the 2002 Governor's Team Award for Excellence in Performance.

Jackie Forba is the acting Chief of the Health Care Resources Bureau which includes Children's Special Health Services (CSHS) and the Children's Health Insurance Plan (CHIP). She is the CHIP

Section Supervisor and has worked with CHIP for the past six years. Prior to this, she was a Program Specialist with the Women's and Men's Health Section in the Family and Community Health Bureau for ten years. Jackie served on the Jefferson County Board of Health for four years and was the Business Manager of City Park Internal Medicine, PC in Denver, Colorado for seven years. Jackie Forba, Acting Bureau Chief of the Health Care Resources Bureau.

Bette Jo Archambault, RN is Acting Program Manager for Children's Special Health Services. Ms. Archambault is a registered nurse with a BSN from Montana State University, Bozeman, MT. She has practiced as an inpatient medical nurse and post-partum OB, home health nurse in NM, and AZ, public health nursing in MT and VT, and family planning nurse in NY. Since returning to Montana eleven years ago, Ms Archambault has been a nurse consultant with the MCH Bureau and CSHS Program.

E. STATE AGENCY COORDINATION

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees and functional work committees.

There are two Advisory Councils that advise the department on programs and services in the Family and Community Health Bureau and the Children's Special Health Services program. The Family and Community Health Bureau Advisory Council is charged with advising "… the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services on matters impacting the Bureau's target populations, including pregnant women, women of childbearing age, infants, children to aged 22." The AC Purpose and Guidelines document and the list of 05-06 members is attached. The Council meetings every two months via TC, and advises the department in the interim via e-mail and by phone.

The Family and Community Health Bureau Advisory Council is instrumental in helping link and guide the Bureau. In Calendar 06, the Bureau will undergo a strategic planning update, facilitated by the PHPS and informed by the needs assessment submitted in this application. The strategic planning process will include AC members, contractor representatives, program managers and staff. The FCHBAC members provided effective advocacy for MCH programs during the 2003 and 2005 State Legislature and played key roles in preserving the state's general fund support of the public health home visiting program for high-risk pregnant women and infants addressed in legislation as Montana's Initiative for the Abatement of Mortality in Infants or MIAMI.

The Children's Special Health Services (CSHS) section is located in the Health Care Resources Bureau and coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS also works towards coordination at the state level. The State CHIP program is also contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau participates as a staff member on the CSHS Advisory Group.

The PHSD and FCHB also have other Advisory Councils. At present, the PHSD has approximately 35

councils, many of them linked to specific grants. The FCHB has The Birth Outcome Monitoring AC, The Dental Access Coalition, the Family Planning Medical Standards Committee, Fetal Alcohol Syndrome Advisory Council, Fetal Infant & Child Mortality Review Work Group, the Newborn Hearing Screening Task Force, Newborn Screening Advisory Board, the Suicide Prevention Work Group and the WIC Steering Committee. The Governor's office is examining all ACs, and anticipating combining some of these functions into the FCHB AC structure, which will be done over the next year.

FCHB and HRCB Staff participates on several intra and interagency groups targeting the MCH population. Examples of those groups include:

Connecting for Kids -- Primarily designed as an intra agency group, this group began meeting in 2004, in order to address challenges of linking existing programs and services. Programs, including DD, foster care, and others, were facing instances in which children's insurance or other services stopped with no transition plan. This group's stated purpose is to "… look at the systems that serve children in Montana, to enhance coordination of programs, and improve communications between programs to deliver services in the most efficient manner possible".

Healthy Kids - Quarterly meetings are held with the Office of Public Instruction (which is the state's Department of Education) in order to discuss issues that cross departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and management of asthma. Dennis Cox helps facilitate that group, setting the agenda every other meeting.

Kid's Count Advisory Council -- This projects is directed by the Bureau of Business and Research of the University of Montana. Funded in Part by the Annie E. Casey Foundation, this project helps to inform health policy discussion and decisions. The project publishes and distributes a Montana specific report every year. This advisory council meetings quarterly. The department also supports the printing and distribution of the Kids' Count Book to local communities.

March of Dimes Board of Directors -- This board meets monthly. Jo Ann Dotson represents public health on this board. The Bureau shares common goals to improve pregnancy outcomes and decrease infant mortality, including that attributable to prematurity, with the March of Dimes organization.

F. HEALTH SYSTEMS CAPACITY INDICATORS

The examination of population-based indicators that typically present a broad picture of a state's public health serves to clarify both strengths and weaknesses in the public health delivery system and the need for reliable data. This initial introduction of Health Status Indicators will identify strengths and challenges of the state's data collection system.

The Health System Capacity Indicators (HSCI) for Montana give a broad-brush picture of state public health capacity to meet basic population-based needs. They do not, however, illuminate the health service disparities between urban and rural or majority and minority citizens. And, they do not represent all services provided to all citizens. Because Montana lacks statutory authority to require reporting of hospital discharge data for all citizens, Montana's statistics rely solely on Medicaid paid claims data.

HSCI 01: The rate of children hospitalized for asthma (ICD-9 codes 49.3.0-439.9) per 10,000 children less than five years of age. This indicator has varied over the six-year span of 1998 through 2004, but is quite low overall, with current crude numbers less than 100 (n=82), representing 0.15% of the population at risk. Data includes only Medicaid paid claims data and services paid by no other funding sources. A five-year CDC grant for $2.5m to develop Montana's environmental health tracking capability will include a pilot project on asthma and is expected to generate more representative data

through case ascertainment for a statistical sampling of Montana's children.

HSCI 02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen. This percentage has ranged from 83% - 98% over the past five years. Current statistics suggest 84.3% of all SCHIP enrollees under 1 year of age had at least one periodic screen.

HSCI 03: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen. This data is not maintained by the Montana's CHIP program. Therefore, the data presented in HSCI02 is considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP.

HSCI 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 on the Kotelchuck Index. Current statistics suggest 81.1% of women 15 to 44 with a live birth for the reporting year achieved 80% on the Kotelchuck Index score for the observed to expected prenatal visits. These data are generated from the birth certificate and depend on the completeness of completion of that certificate by the birthing facilities. Because the data appear consistent, it is likely that this represents a fairly accurate indication of the average level of prenatal care across the state.

HSCI 05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the state by (a) percent of low birth weight (<2500 grams); (b) infant deaths per 1,000 live births; (c) percent of infants born to pregnant women receiving prenatal care beginning in the first trimester; and (d) percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% on the Kotelchuck Index) Data is only available for the total Montana population and is not broken out by pay source between Medicaid and non-Medicaid. Over the period of 1998 through 2002, an average of 6.7% of the annual birth cohort of 11,000 in Montana is born weighing less than 2,500 grams. Current statistics suggest this trend may be increaasing, with 7.6% of the total Montana birth cohort being of low birth weight in 2004. Infant deaths currently represent 4.1 per 1,000 live births (0.4% of the total birth cohort). Approximately 82.8% of all infants were born to women who received prenatal care beginning in the first trimester. Approximately 81.3% of all women with a live birth for the reporting year achieved 80% on the Kotelchuck Index score for the observed to expected prenatal visits.

HSCI 06A: The percent of poverty level for eligibility in the State's Medicaid programs for: (a) infants (0-1) is 133% of poverty or, if born to a Medicaid recipient mother no income declaration is required through 13 months of birth; (b) young children (1 year through the 5th year) is 133% of poverty; (c) children and adolescents (6 years through the 18th year) is 100%; and (d) pregnant women is 133% of poverty regardless of age range.

HSCI 06B: The percent of poverty level for eligibility in the State's SCHIP programs for children birth through 18 is is 150% of poverty. Pregnant women are not covered by CHIP in Montana unless they are 18 or younger and meet the income requirement.

HSCI 07:The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year. The data continues to reflect the loss of dental services in Montana and the low Medicaid reimbursement rate for the remaining providers of dental services. For the years 1999 to 2004, the percentage of EPSDT children receiving at least one dental service varied from 46% to 26.7% respectively.

HSCI 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program Data from 1998 through 2004 demonstrate decreasing service trends, from 3.5% to 1.0% respectively. Montana children and youth who qualify for SSI continue to qualify for Medicaid. Referrals from SSI are reviewed and applications, clinic invitations or case management referrals are made as appropriate for each client. Staff assists families with the SSI process by linking them with a community-based

case manager to facilitate that process.

HSCI 09A: The ability of States to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data. The Public Health Data System collects information on maternal and child risk factors, home visiting criteria, and referral information for the promotion of policy and program-relevant information. States have access to the data through IT and the user interface, so reports can be generated as needed at the program and state levels.

HSCI 09B: The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month. YRBSS data is collected through the Office of Public Instruction to ascertain this data.

HSCI 09C: The ability of States to determine the percent of children who are obese or overweight. YRBSS data is collected through the Office of Public Instruction to ascertain this data.

HSCI 10: Geographic living area for all resident children aged 0 through 19 years old. Data suggests 46.0% of all Montanans live in a rural area in Montana. We currently do not have data on children through the age of 19 for the geographical area designations. Therefore, the crude 0-19 child population frequency from the 2000 Census was used as the denominator data and 46% of that number generated the proportion of 0-19 year olds living in rural areas. Also, frontier and metropolitan designation data could not be ascertained for the health status indicator. Percentages were compiled by the Census and Economic Information Center at the Montana Department of Commerce for 2000.

HSCI 11: Percent of the state population at various levels of the federal poverty level. Data for 2003 indicates out of a population of 902,195, 5.7% are at the 50% below poverty level, 15.1% are at the 100% below poverty level, and 36.4% are at the 200% below poverty level. These estimates came from the CPS Annual Demographic Survey.

HSCI 12: Percent of the state population aged 0 through 19 at various levels of the federal poverty level. Data for 2003 indicates out of a population of 257,440, 8.0% are at the 50% below poverty level, 18.0% are at the 100% below poverty level, and 39.0% are at the 200% below poverty level. These estimates came from the 2002 Kid's Count data for Montana.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The needs assessment document is an opportunity to compile data and reflect on the complete picture of MCH needs and programs in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning process will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau within the Montana Department of Health and Human Services submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the final document. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Mangers is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the development of the surveys, and reviewed and advised on the content of the final needs assessment document.

B. STATE PRIORITIES

Selection and prioritization of state needs is an ongoing process requiring assessment of health status and system functioning indicators as well as availability of financial and human resources. Changing expectations of public health impacts the priority selection. The evolution of public health in Montana and the nation continue, moving from what was essentially individually-based services, often providing primary care or a proxy for primary care services towards a system that is population-based, including needs assessment, policy development and assurance. Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent in communities where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure.

The following list of priority needs was generated based on a statewide survey of consumers and those caring for infants, children and families. A copy of the consumer and professional survey is attached to this section. The survey was distributed to WIC and Head Start clients, WIC and Head Start program staff and primary care and public health providers.

This survey provided public input into the development of a list of priority needs, which was further assessed based on the following criteria:

· Existence of data supporting the need
· Evidence that the MCH population, including infants, children, adolescents, children with special health care needs, women of childbearing age and their families were the target audience of the priority.
· Availability of resources and capacity within the public health system (not necessarily the MCH agency) to help address the issue.

This priority list will be the basis of the strategic planning process, which will involve the FCHB Advisory Council, the FCHB staff and local partners and consumers during FFY 06. The needs assessment will inform participants in the strategic planning process. It is anticipated that further prioritization will take place during the strategic planning process, and that the priority list will continue to change and evolve as new data, which will be part of the ongoing needs assessment, is revealed.

This list does not address overarching issues, which impact every one of the priorities. The issues include:

· The importance of a functioning public health system -- the public health system addresses the core functions of public health including assessment, policy development and assurance through the essential services. Included in those services are the responsibility to have appropriate training of public health professionals and partners, epidemiological capacity with which to analyze information regarding the population, and excellent networking among traditional and non-traditional public health providers.
· Recognition of disparity and its impact on the health of the MCH population. -- Examples include disparity in the efforts to promote the health of females in society, as well as disparity between ethnic groups, age groups (i.e. school-aged children) and urban and non-urban dwellers. Recognition of, and efforts to address these disparities is an overriding concern, as they impact all MCH priorities.

Priority Issues

1. Increase access to health care for MCH populations, including children with special health care needs.
2. Increase insurance coverage of MCH populations.
3. Promote and improve oral health services for MCH populations.
4. Reduce the rate of intentional injuries in MCH populations, including, but not limited to the incidence of domestic violence and youth suicide.
5. Promote and support families to raise children in safe and nurturing environments.
6. Reduce the rates of preventable illness in children and adolescents, including obesity and vaccine preventable illnesses.
7. Prevent substance use in MCH populations.
8. Promote access to mental health services for MCH populations.
9. Promote efforts to continue to decrease the incidence of unintended pregnancies.

Efforts to update and re-examine priorities are done annually, in the form of pre-contract surveys to all contract counties. The surveys are distributed in February of each year, and elicit county responses on topics such as the priority needs impacting the MCH target populations. The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys. Staff also has the responsibility to monitor data and available statistics.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			99.9	99.9	100
Annual Indicator			100.0	100.0	100.0
Numerator			6	4	2
Denominator			6	4	2
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2003

Prior year data used incorrect denominator and numerator -- was reporting total births and total screened, which is NOT what was required here.

Notes - 2004

Two cases of galactosemia were referred for case management by nurse consultants in Children's Special Health Services.

Mandatory tests in MT = PKU, Galactosemia, Congenital Hypothyroidism, hemoglobinopathies.
Optional tests available = Cystic Fibrosis,
· Congenital Adrenal Hyperplasia , Biotinidase Deficiency* ,· Acylcarnitine Profile*
Fatty Acid Oxidation Disorders
§ Medium Chain Acyl-CoA Dehydrogenase Deficiency
§ 3-Hydroxyacyl CoA Dehydrogenase Deficiency
§ Very Long Chain Acyl-CoA Dehydrogenase Deficiency
§ Short Chain Acyl-CoA Dehydrogenase Deficiency
§ Carnitine Palmitoyltransferase Deficiency
§ Glutaric Acidemia Type II
§ 2,4 Dienoyl-CoA Reductase Deficiency
§ Trifunctional Protein
§ Isobutyryl-CoA Dehydrogenase Deficiency
§ Short Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
§ Carnitine Translocase Deficiency
§ Carnitine Uptake Deficiency
o Organic Acidemia Disorders
§ Glutaryl CoA Dehydrogenase Deficiency Type I

§ Propionyl CoA Carboxylase Deficiency
§ Methylmalonic Acidemia (mutase, Cbl A and Cbl B, Cbl C and Cbl D)
§ Isovaleryl CoA Dehydrogenase
§ 3-Methylcrontonyl CoA Carboxylase Deficiency
§ Mitochondrial Acetoacetyl CoA Thiolase Deficiency
§ 3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency
§ Malonic Acidemia
§ 3-Methylglutaconyl CoA Hydratase Deficiency
§ Medium Chain Hydroxy Acyl-CoA Dehydrogenase Deficiency
§ Medium Chain 3-Ketoacyl-CoA Thiolase Deficiency
§ 2-Methylbutyryl CoA Dehydrogenase Deficiency
§ Multiple Carboxylase Deficiency
§ 2-Methyl-3-Hydroxybutyryl CoA Dehydrogenase
· Aminoacidopathies* (tested by Tandem Mass Spectrometry - MS/MS) (CPT code: 82136, cost $4.25)
o Maple Syrup Urine Disease
o Homocystinuria
o Citrullinemia
o Arginninosuccinic Acidemia
Tyrosinemia (type I, II, III)

a. Last Year's Accomplishments

In 2004, Montana's required panel of four tests (PKU, galactosemia, congenital hypothyroidism and hemoglobinopathies) were performed on 100% of the in-state reported births. Only one PKU case was identified and that infant expired shortly after confirmation. There were 2 children with confirmed cases of galactosemia, both of whom were referred to Children's Special Health Services for case management and treatment in accordance with State procedures. There were 38 children identified with a specific trait of hemoglobinopathy, but none was confirmed with sickle cell disease in 2004. There were 13 children with initial abnormal tests for congenital hypothyroidism, but none were confirmed as having this condition.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Determine cost of linking newborn hearing screening and metabolic screening for referral to CSHCN				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2005, Montana's required panel of newborn heelstick screening tests remains unchanged. Optional tests are available -- some through the Montana Public Health

Laboratory and others through out-of-state laboratories. Newborn screening, monitoring, and follow up continue to involve collaboration between all the birthing facilities in Montana (currently 37), midwives, the Montana Public Health Laboratory, staff in the Maternal and Child Health Data Monitoring Section of the Family and Community Health Bureau, staff in the Children's Special Health Services Section of the Health Care Resources Bureau, and the medical homes of the newborns.

c. Plan for the Coming Year

Montana has combined newborn heelstick and hearing screening monitoring and management of the State's birth defects registry into one position. This position receives data management support and epidemiological support from other FTE's in the MCH Data Monitoring Section.
Almost universally, the same staff in the birthing facilities perform/ensure the performance of both the newborn heelstick and hearing screenings. State-supplied technical support for ensuring the validity of the heelstick screening is provided by the Montana Public Health Laboratory. State support of the initiation, follow up and reporting of both heelstick and hearing screening is provided by the newborn screenings monitor/educator in the MCH Data Monitoring Section.
Consolidation of the screening monitoring function reinforces with the community partners that both components of screening should be considered standard practice and equally important for early detection and intervention. In mid-2005 the hearing screening monitoring software will be matched with birth certificate data to ensure universal screening of the newborn population. In 2006, linking this matching procedure with metabolic screening will be examined and the cost determined for funding raising efforts.
Management of the birth defects registry for Montana's annual birth cohort of <12,000 will occupy the other .50FTE of the time of this position. Epidemiological support will be provided by other staff in the same Bureau.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	0	0	54.2	54.5
Annual Indicator	NaN	NaN	54.0	54.0	54.0
Numerator	0	0	188	188	188
Denominator	0	0	348	348	348
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective	55	55.3	55.6	55.6	55.6

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

Reporting on this performance measure is unchanged. Ongoing client satisfaction surveys are conducted at Pediatric Specialty Clinics. The Billings regional clinic site reports a 98.19% satisfaction rating on being involved in decisions and being listened to during clinic visits. This sample is small and therefore not representative of the cshcn population in general. This number will be modified in 2005 to represent a larger sampling of cshcn clients.

a. Last Year's Accomplishments

2004

CSHS supported travel to specific conferences for parents of CSHCN. CSHS refined a policy to 1) increase the availability of funding by limiting the per trip amount and 2) to establish a process for parents to share the information they receive during the selected training. CSHS implemented policy to provide financial assistance with travel and respite costs for parents who participate on the CSHS advisory committee. This policy enabled more parents to participate in a leadership role. CSHS continued to support active parent and YSHCN participation in the CSHS Advisory Council.

The annual summer CSHS coordinator and provider conference included presentations by YSHCN and parents of CSHCN. The presentations were the highlight of the conference and provided conference attendees a true understanding the impact of chronic conditions. Pediatric providers, early intervention providers, parents, school and public health nurses, and therapists attended the conference.

Parent satisfaction surveys are conducted at periodic intervals for regional pediatric specialty clinics. Survey results indicate families are pleased with the services they receive and that the clinic sites are readily accessible.

A comprehensive change was made in cleft/craniofacial clinic documentation provided to parents and service providers. Satisfaction surveys indicate both groups find the new format easier to read and use.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Active parent and youth participation in CSHS advisory board				X
2. Annual CSHCN diagnosis specific conference with family participation/presentation				X
3. Ongoing parent satisfaction survey's--Regional Pediatric Specialty Clinics				X
4. Application for incentive award to fund parent projects--CSHS partnered with parents, PLUK--statewide parent education group				X
5. Ongoing parent partication in Champions for Progress meeting to identify current performance measure goals for state.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005

CSHS has worked diligently to find creative solutions to improving performance in this area. This year CSHS continued building on its partnership with Montana's Parents Let's Unite for Kids (PLUK) family advocacy program. In cooperation with CSHS, PLUK applied for an incentive award from the Champions for Progress Center at the Early Intervention Research Institute with the goal of increasing family participation in CSHS program decisions. If funded, the success of this project will be evaluated, in part, with the use of Form 13 of the MCH Block Grant as determined by parent project participants. Writing the incentive award proposal was a shared activity between parents, PLUK and CSHS. A parent project leader has been identified to take the lead in accomplishing the goals of the project. CSHS continues to extend parent representation on the CSHS family advisory council.

The 2005 summer CSHS annual conference will include parents as trainers and consultants.

c. Plan for the Coming Year

2006

CSHS will continue the activities of the current year with the evaluation of and continuation of parent project activities. CSHS is committed to providing parents and youth with special needs the opportunity to have meaningful involvement in their state cshcn program and the services they receive. CSHS plans to identify and commit resources to continued parent involvement when the incentive award expires. CSHS plans to conduct a a short survey to assess parent involvment satisfaction. CSHS program and Regional Pediatric Specialty Clinic participants will be surveyed. Our goal is to also involve other CSHCN service programs and providers in the survey process so that more parents will have the opportunity to provide input. Logistics for this are underway.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	0		52	52.2
Annual Indicator	NaN	NaN	51.7	51.7	60.0
Numerator	0	0	361	361	15982
Denominator	0	0	698	698	26636

Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60.2	60.4	60.6	60.8	61

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

Number is calculated on 12.8% of populaton under age 18 x CSHS program information for cshcn with medical home.
With the continued focus on coordination of care within the medical home by programs such as EPSDT, this number is expected to continue to increase.

a. Last Year's Accomplishments

2004
CSHS has established accurate baseline data through the recording of the medical home for all children utilizing specialty clinic services. Parents also record when their child last saw the primary physician, dentist, and specialists involved in the child's care. In 2004, 60% of the CSHCN who received services from CSHS reported having a primary care provider.

By policy and standard of care, the medical home physician was incorporated as an extended member of a child's pediatric multidisciplinary specialty team.

The CSHCN Director and the Advisory Committee Vice Chair, Dr. Marian Kummer, was awarded a grant from the American Academy of Pediatrics (AAP) Community Access to Child Health (CATCH) funding program. The grant funded a series of focus groups and planning events to determine how to provide optimal care management for children with special health care needs within a medical home. Participants included physicians, nurses, early intervention agencies, and parents. Two practices participated in this project, the Children's Clinic in Billings and Family Practice in Wolf Point Montana. CSHS assumed coordinating activities of the grant. CSHS staff assisted with parent and community groups to discuss the need for optimal care coordination to increase community-based care and decrease stress to parents trying to navigate the system. The medical-home project helped establish CSHS presence in the need for improved access to medical homes. The CSHCN Director presented at the Montana Chapter of AAP in September regarding the CSHS program and the medical home philosophy. Through the focus groups, parents identified that it is difficult for them to find all of the resources in their communities, coordination of school and health services is a problem, and that a website is needed to provide a statewide comprehensive link for services for CSHCN in Montana.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Specialty services brochure developed and provided to PMD's and others providing care to CYSHCN				**X**

2. Participation in Catch grant with Dr. Marrion Kummer regarding providing optimal care management for CYSHCN with medical home				X
3. Tracking and referral to medical home for all regional pediatric specialty clinic participants				X
4. Promote medical home concept and raising awareness though partnerships with EPSDT Program, Part C early intervention programs, NHSP, TCM, EPHT, and education programs.				X
5. Provide clinic reports from cleft and metabolic clinics to medical home and other health care providers		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

2005
CSHS continued implementing the tracking of medical home utilization for children who receive specialty clinic and other services through the CSHS program.

The CSHCN portion of the MCH BG 5-year needs assessment is being conducted in conjunction with Dr. Kummer's CATCH grant activities. This data will be available during the summer of 2005.

The CSHS website is under development and due for roll out during the summer of 2005. The website will include links with PLUK, Montana's statewide parent advocacy group.

c. Plan for the Coming Year

2006:
CSHS will continue to seek opportunities to raise the awareness of programs that provide information and services to children of the importance the medical home concept. CSHS is active in the process of referring families to their primary care provider and in promoting the medical home concept with working partners, such as the EPSDT Program, Part C early intervention programs, the Newborn Hearing Screening Program, TCM, Environmental Public Health Tracking Program, and the Office of Public Instruction.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	0	0	50	50.3

Annual Indicator	NaN	NaN	48.8	48.8	78.4
Numerator	0	0	350	350	1933
Denominator	0	0	717	717	2464
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.5	78.6	78.7	78.8	78.9

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

Numbers based on active CSHS clients 2004 with a health payment source. Number doesn't include CSHS as a payment source. Adequacy is not measured, but would probably lower this rate. Montana's overall uninsured rate for children 0-18 is 17%.

a. Last Year's Accomplishments

CSHS ability to assist families with financial support decreased during FFY 2004. A total of 133 kids received an average of $1300 in financial assistance. CSHS began evaluating CSHCN who have no other source of medical coverage for programs to assist with medical costs, such as Community Health Centers for medical and dental needs. In addition, CSHS worked with third party payers to cover services needed by CSHCN in hopes to reduce the economic burden on families.

In light of dwindling resources, CSHS implemented a process to refer families to hospital financial assistance programs, prior to using Title V dollars. This was a drastic change for the CSHS program, as previous practice was to access Title V first. From this we have learned there are many community resources that need to be tapped, prior to accessing Title V funds. Additionally we began the process to bill back Medicaid for clinical services to boost funding to the financial assistance program.

The CSHS Outreach Coordinator provided joint training with CHIP and Medicaid staff to two reservation sites, the Montana Public Health Association, as well as the Montana Academy of Pediatrics and Family Practice annual meetings. CSHS outreach is directed towards providing financial resources education to providers and parents of CSHCN

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide limited finanial assistance with specialty care for qualifying children/families	X			
2. Review health coverage information for all regional pediatric specialty clinic participants and referral to programs when needed		X		
3. Regional Specialty clinic sites and CSHS are applying for provider status from Medicaid and insurance programs. Clinic participants will be				

billed--CSHS will continue to underwrite payment for underinsured and uninsured clinic participants. Provides				X
4. Continue to partner with CHIP for referral/resouce information for CHIP/CSHS applicants.		X		
5. Contine to partner with Medicaid and CHIP for approval of payment for orthodontic care for CYSHCN with craniofacial conditions				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS is working actively with Medicaid and CHIP contractors to establish CSHS as a provider for CSHCN receiving services through the Regional Pediatric Specialty Clinics. Other insurance companies will be included in the near future. This will provide CSHS with additional funding to offset clinic costs for the underinsured and uninsured in Montana.

To validate the CSHCN national survey, CSHS surveyed 250 willing CSHCN families attending specialty clinics during September through December of 2005 regarding health insurance coverage and their opinion regarding adequacy of coverage. To date, we have a rough indication from this survey approximately one-fifth of those participating were without insurance coverage or a payment source for care in the year prior to the survey. A majority of the respondents indicated the insurance source or payment source permitted the child to see needed providers or have needed services.

CHIP legislative successes assure the enrollment of an additional 3,000 children on CHIP and increasing the mental health benefits for CHIP children who have a serious emotional disturbance.

Because not all agencies were using the Universal Application for financial assistance, the Universal Application was shortened for ease of use. CSHS continues to make and receive referrals from CHIP.

c. Plan for the Coming Year

CSHS will continue the process begun toward establishing CSHS as a provider with Medicaid, CHIP, and other insurance companies to allow CSHS to begin the billing for CYSHCN attending the Regional Pediatric Specialty Clinics. The expectation is the billing will assist with recouping a portion of the clinic costs thus providing some additional funding to assist CYSHCN/ families who are uninsured or underinsured. CYSHCN will continue to partner with Medicaid and CHIP to cover orthodontic care for CYSHCN with craniofacial conditions. Efforts to provide resource and referral information, education to community providers and families of CYSHCN will continue as well as information regarding self-advocacy strategies.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	0	0	0	71.9	72.2
Annual Indicator	NaN	NaN	71.6	71.6	71.6
Numerator	0	0	250	250	250
Denominator	0	0	349	349	349
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	72.4	72.6	72.8	72.8	72.8

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

CSHS completed a capacity analysis of the two existing pediatric regional clinics sites and determined that a third site is needed to address the needs of Montana CSHCN families. CSHS continued financial support, training, and consultation to the regional clinic sites. The regional pediatric specialty clinic programs are active participants in the provision of services to Montana's CSHCN.

CSHS initiated a partnership with the Montana School for the Deaf and Blind (MSDB) to provide identification of sensory impaired infants and children, as well as a mechanism for tracking early intervention and on-going education services to ensure that appropriate educational services are consistently implemented to successfully impact and mitigate the detrimental effects that the early onset of deafness has on language development, and that vision loss has on the concept development and communication skills of infants, toddlers and school age children served in both community-based and public school programs.

CSHS regained the management of the Medicaid targeted case management (TCM) program for children with special health care needs. This past year was spent re-establishing relationships with providers, listening to their concerns and needs and establishing a forum to redesign this program. This activity brought together a mix of public and private providers to reach consensus regarding TCM activities and how to interface and access services.

Given time and resource constraints, CSHS did not compete for the respite grant as previously reported.

Montana children have access to a variety of community-based services in multiple systems,

however there has been limited cross coordination with such services. During this year we have had the opportunity to begin a dialogue with Part C providers regarding financial assistance available to families. The Part C system was adamant (per NTECH) that Title V must pay before Part C. This allowed CSHS to provide education regarding the Title V program and led to an interagency agreement regarding who pays for what. We have been successful, with the exception of those children with hearing loss.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing financial support, training and consultation for Regional Pediatric Clinic Sites				X
2. 3rd Regional Pediatric Clinic Site (to complete regional clinic coverage) will be developed in FFY 2006.				X
3. Partnering with MSDB for educational services to CYSHCN with sensory impairment				X
4. Electronic link with MSDB				X
5. Updating of TCM definitions and policies for CYSHCN to increase effectiveness of community care coordinators to enable families to access cost-effective services readily.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS participated with a committee convened by the Montana Office of Public Instruction to revise Montana's technical assistance manual titled "Serving Students With Special Health Care Needs". The committee met several months to create a manual consistent with current legal requirements and promising practices. The purpose of the manual is to provide guidance to school personnel and health care providers in serving the students with health care needs in the educational environment. An intended outcome of the manual is to create and strengthen partnerships between educators, parents, and health care providers. A third regional pediatric specialty clinic site, which will be located in Great Falls has been approved by the CSHS advisory board and will be developed as a cooperative venture between Benefis Hospital, the Great Falls Pediatric Clinic, and CSHS. A site has been tentatively identified. Funding for establishing this clinic was allocated through an increased tax on tobacco products during the 2005 legislative session. Expectations and discussions regarding qualifications of the regional clinic site are underway.

In order to strengthen the MSDB partnership, an electronic link is being added to the CSHS database, CHRIS, to facilitate tracking and shared services for hearing and vision impaired infants, children, and youth and will be tested during the summer of 2005.

Ongoing parent satisfactions surveys are conducted at periodic intervals for regional pediatric specialty clinics. Survey results indicate families are pleased with the services they receive and that the clinic sites are readily accessible.

A comprehensive change was made in cleft/craniofacial clinic documentation provided to parents and service providers. Satisfaction surveys indicate both groups find the undated formatting easier to read and use.

As the TCM project unfolded, a department wide initiative was launched to coordinate all Medicaid TCM activities. A working definition of CSHCN was approved to clarify the service population for public health nurses who provide case management services. Qualifications of CSHCN providers were established. The TCM policy and procedures manual is being updated. TCM activities are being designed to increase the effectiveness of care coordinators to enable families to access cost-effective services readily.

To provide a stable source of funding for the regional pediatric specialty clinics, a multidisciplinary clinic billing function is being developed. Legislative authority for this activity was granted during the 2005 Legislative session. Billing revenue will assist with sustainability of clinic services especially in light of the fact that the specialty clinic sites require a significant financial contribution from the hospitals in which they are located.

c. Plan for the Coming Year

Tobacco tax funding to establish the third clinic site will be available in January of 2006. The first step in the process will be the hiring and training of a clinic coordinator and support staff.

CSHS plans to begin billing for multidisciplinary clinic services for cshcn attending cleft/craniofacial and metabolic clinics in the fall of 2005. When this process has been successfully completed, the regional clinic sites will begin billing also. CSHS is committed to continuing using MCH funds to allow access to multidisciplinary clinics for those cshcn who are uninsured and underinsured.

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Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				6	6.5
Annual Indicator			5.4	5.4	5.4
Numerator			8	8	8

Denominator			147	147	147
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6.5	6.5	7

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

No change has been made in the data from previous year.
This TA is being requested. Transition issues are discussed on-going in the multidisciplinary Regional Pediatric Specialty Clinics on a provider- to-CYSHCN/family basis covering the issues faced at the appropriate developmental stages. CSHS has established a collaborative relationship with the Office of Public Instruction and Vocational Rehabilitation with a goal of exploring how this information might be attained and how to improve transition services.

a. Last Year's Accomplishments

During 2004 CSHS clinic staff and regional clinic staff continued to provide transition information on a one-to-one basis to youth attending specialty clinics.

CSHS developed policy and an application process for sponsoring families to obtain condition specific information for transition and health planning by assisting them in attending conferences or other educational opportunities. One Youth with Special Health Care Needs (YSHCN) attended a conference that addressed issues of independent living skills for young adults.

Due to severe staffing limitations CSHS was unable to implement the Transition Timeline for Children and Adolescents with Special Health Care Needs (Adolescent Health Transition Project of the University of Washington) in the specialty clinic program. CSHS recognizes that transition service coordination is an ongoing and priority need in Montana.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Brief transition assessment/counseling of Regional Pediatric Clinic Site participants.	**X**			
2. CSHS is establishing a partnership with Vocational Rehab Services and the Office of Public Instruction for transition related services/information				**X**
3.				
4.				
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b. Current Activities

CSHS provides counseling to youths who are participants in pediatric specialty clinics regarding health insurance, procuring pharmaceuticals/prescription drugs, and selecting adult specialists is an ongoing activity. CSHS staff also continues to work one to one with families who need assistance in these areas for their children who are transitioning to adulthood.

Many agencies providing services to children and youth with special health care needs are involved in transition activities. The school system is required by law to have a transition plan in place for students leaving the education system. Montana continues to lack a comprehensive plan to address all of the transition issues families and youth with special health care needs. Efforts to pull together all the players involved with transition issues continue to be a priority continue to priority activities for CSHS.

CSHS continues to offer families and youth the opportunity to attend informational training.

CSHS is establishing a new partnership with Vocational Rehab Services to provide specific and general referrals to vocational training counseling and services. CSHS has proposed expanding our advisory council membership to include representation from Vocational Rehab.

c. Plan for the Coming Year

CSHS will continue to build partnerships in the transition area of services. With parent and youth input, CSHS will tailor transition information to meet the needs of Montana's population.

CSHS will continue to work with and support partners such as Family Voices and parent training/advocacy groups in the development of a multi stage transition plans. Transition information will be distributed widely through CSHS partner agencies.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	90	90
Annual Indicator	94.4	91.6	90.7	89.7	90.9
Numerator	2445	9809	2610	2440	2603
Denominator	2591	10709	2878	2721	2864

Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	91	91	91	92	92

a. Last Year's Accomplishments

Immunization rates: Statewide vaccination rates (the series combination of 4DTaP, 3 Polio, 3 Hib, 1 MMR, 3 HepB) for children aged 24-35 months of age seen in clinic and provider sites in Montana during 2003 was 89.7%.

The data were collected from 54 of the 56 counties with public and private vaccine providers and represented
25.41% of the birth cohort. Hepatitis B vaccinations:

The Montana State Legislature enacted universal Hepatitis B testing of all pregnant women during each
pregnancy. Universal vaccination of all newborns is being implemented across the state without legislative mandate. 91% of the newborns are receiving this birth dose before they leave the birthing facility.

"Reading Well" collaborative project developed with Medicaid and the Office of Public Instruction. When children complete their 2 year old immunizations, or their pre-kindergarten immunizations, the families can present the completed short record to the county health department, for entry of the record into the immunization registry, and the family can choose a book from "the reading well." This is a win-win project. Families are encouraged to read with their children, and the incentive helps populate the
immunization registry.

Incentive developed to encourage WIC families to provide children's immunization record for evaluation. If the families bring their shot records for entry into the immunization registry, they are given an opportunity to put their name in a drawing for a chance to win a gift certificate to a local grocery store.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract co Hlth Depts for immunizations and Maintenance of statewide immunization registry			**X**	
2. VFC vaccines to tribal clinics, co hlth depts & register provate providers for elibible children			**X**	
3. Contract with co Hlth Depts to evaluate immunizationn records of children in day care setting			**X**	
4. Contract wi co Hlth Depts to establish a relationship w/WIC to assess immuniation history of WIC children- provide vax or refer			**X**	
5.				
6.				
7.				

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b. Current Activities

The National Immunization Survey covering Q3/2002-Q2/2003 found the immunization rate of children 19-35 months of age in Montana to be 75.4% (+6.4) for 4DTP: 3Polio: 3Hib: 1MMR: 3HepB. The rate on this survey for varicella indicates the varicella rate was just 66.3% (+6.8). Because Montana provider rates are very low for administration of that antigen, Montana Immunization Program targeted varicella education as a priority with the private and public vaccine providers. During the Regional Immunization Workshops in 2003, this was a major point of discussion.

Feedback following the clinic site review in each provider office during 2004 includes a discussion of their rate for varicella vaccinations.

Because of a decrease in CDC funding for immunizations in 2004, the State Immunization program is unable to continue to contract with the counties for the adolescent immunization activities that were initiated in 2001.

The interface between the electronic birth certificate and the PHDS has been completed and tested. Full implementation is being delayed until an enhancement to the client record matching process in PHDS has been made.

c. Plan for the Coming Year

The Immunization Program maintains contracts with 52 counties and 7 tribes to provide immunization services across the state. Federal vaccines through the Vaccines for Children (VFC) Program are provided to 96 private providers and approximately 100 public providers to administer age-appropriate immunizations to VFC-eligible children.

Continued effort to finalize MOU with WIC in order to facilitate coordination on immunization monitoring.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23	19	19	18.5	18
Annual Indicator	18.6	17.6	17.4	15.3	16.4
Numerator	398	377	373	327	350

Denominator	21378	21378	21378	21378	21378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	15	14	13	12	12

a. Last Year's Accomplishments

The Department includes the prevention of teen pregnancy as one of its key issues in public health. In 1997 the state Legislature mandated a 10% reduction in the state's 5-year teen pregnancy rate by the end of the 1999 biennium, although no additional funds were allocated. A recent update of Montana 2002 data shows that a 14% reduction has been achieved.

The Governor's Interagency Coordinating Council (ICC) adopted Montana's teen pregnancy rate as one of only five key benchmarks for State Prevention Programs. This Council was formed with the stated mission "to create and sustain a coordinated and comprehensive system of prevention services in the state of Montana" until budget cuts severely reduced the program in 2002. The WMHS holds a leadership role in teen pregnancy prevention efforts for the Department. The WMHS Health Educator acts as the Department's Teen Pregnancy Prevention Coordinator and was an active member of the workgroup associated with the ICC when it was fully functioning. This workgroup carried out a vigorous plan that included meetings and prevention activities every three weeks throughout the year.

The Program Specialist acts as a key resource for the collection and dissemination of teen pregnancy data. The Trends in Montana Teen Pregnancies and their Outcomes From 1981 - 2000 report has been updated. The updated tables are available to be distributed to local family planning clinics, county health department personnel, media contacts, public policy makers, and university students. Recent data for 2002 shows that the five year (1998-2002) teen pregnancy rate continues to drop for 15-19 year olds and is currently 50.2/1,000. This represents a 14% reduction from the 1993-1997 rate of 58.4/1,000.

The Montana Title V Abstinence education project is now located under the Human and Community Services Division. Abstinence-only until marriage is a component of Teen Pregnancy Prevention and WMHS works with the abstinence coordinator on collaborative prevention activities, as appropriate.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Contract with clinics for reproductive health care, including funding for high-cost contraceoptives				
2. At least 28% of FP clients sered by local clinics will be 19 year and under.				
3. 100% of local clinics will outreach to youth at high risk of teen pregnancy and birth.				

4. The FP Ed. Committee will assess and coordinate training as needed for local clinic staff				
5.				
6.				
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9.				
10.				

b. Current Activities

The WMHS is distributing the updated Trends in Teen Pregnancy report to local partners focusing on teen pregnancy and teen birth rates, including local health departments, WIC agencies, Offices of Public Assistance, school districts, MIAMI projects, IHS clinics, media contacts and public policy makers. A copy of the report is available on the Department web site.

Educational materials on teen pregnancy prevention are distributed by WMHS staff to local family planning programs, constituents, students, midwives, school nurses and public health contacts. Annually, WMHS staff update the Unintended Teen Pregnancy Fact Sheet for use with legislators, local teen pregnancy coalitions, public health professionals and within DPHHS.

The WMHS, MAP, and the STD/HIV section are jointly working on an abstinence policy working group. This group will develop a common policy on abstinence to be used by the different sections and divisions of the Department.

During SFY2004, the WMHS applied for and received special grant funding for local Male Adolescent Clinics; for Information, Education and Communication (IEC) projects; for Client, Family and Community Involvement (CFC); for Family and Intimate Partner Violence and for Efficacious Contraceptives. Local male clinics use teen male interns to reach an increased number of male clients. The IEC projects fund local clinics to increase awareness of family planning services and to increase knowledge on reproductive health. The CFC projects focus on outreach to special needs populations, parents and school districts to increase awareness and support for family planning services. Research shows that victims of family violence are at increased risk of unintended pregnancy.Through special funds for highly effective contraceptives, including emergency contraceptives, the WMHS focuses on reducing the teen pregnancy rates as well as the teen birth rate.

c. Plan for the Coming Year

The WMHS will facilitate community acceptance of and access to family planning services and counseling for clients of all ages. The WMHS will contract with 15 delegate agencies to provide family planning services in 29 locations throughout Montana. In working toward this goal with local clinics, the WMHS will assure the active and continued involvement of family and community in the provision of family planning services to those in need.

Local clinic staff will continue to participate in the State Family Planning Education Committee facilitated by the WMHS Health Educator. One focus area of this committee will be teen pregnancy prevention and training needs of local clinic staff. A needs assessment will be conducted for local staff to determine training needs.

The WMHS has applied for special initiative funding for male clinics; Information, Education and Communication (IEC) projects; and Client, Family and Community Involvement. A growing emphasis on male responsibility and involvement in teen pregnancy and birth rates continues to increase each year. Teen peer interns hired in local clinics will continue to increase the number of males seen in family planning clinics each year. IEC projects focus on increasing awareness of family planning services and about reproductive health. Some of the IEC funding will be targeted to Native American youth who as a group have a birth rate double that of the Montana teen population as a whole. Funding for Client, Family and Community Involvement focuses on outreach to populations who have difficulty accessing family planning services, outreach to parents, and outreach to school districts to increase awareness and support for family planning services.

The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	39	40	41	42
Annual Indicator	2.1	2.0	5.2	13.0	2.2
Numerator	267	258	668	1683	280
Denominator	12907	12907	12907	12907	12907
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	40	40	40	40

Notes - 2003

The numerator and denominator data for this NPM have been changed for all years to reflect the correct number of third grade children who have received protective sealants on at least one permanent molar tooth in relationship to the US Census counts of the entire population of Montana 8 year olds.

Notes - 2004

Incomplete data - only 280 entered in at time of MCHBG submission.

a. Last Year's Accomplishments

A convenience sample school screening data was received from 139 school sites and entered

into the database. A total of 20,060 screenings were performed in 88 Montana cities primarily by volunteer dental, health, and school professionals during 2002/2004.

Cumulative 2002-2004 school year convenience sample data was collected, entered into the database, analyzed and interpreted.

Screening forms were revised to include recommendations made during a 2002 evaluation meeting with Maternal and Child Health Data Monitoring Section personnel.

Training materials for public health and dental professionals were supplied to screening coordinators on case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).

Ongoing training efforts resulted in an increase of public health and school nurses coordinating and serving as screeners.

The DPHHS Guidelines for School Oral Health Screenings manual was revised to include updated information and feature the new form.

A letter and a copy of the new guideline manual was sent to all school screening coordinators prior to the beginning of the school year encouraging screeners to view the training materials prior to screening.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Controlled sample data will be analyzed by the MCH Epidemiological Statistician, compiled into a report, and utilized in reporting performance measure data and needs assessment activities and reports			X	X
2. Dissemination of the report will include all key stakeholders and partner organizations including members of the Montana Oral Health Coalition, local public health and tribal health offices, and participating schools			X	X
3. Data will be submitted to CDC on behalf of Montana for inclusion in the National Oral Health Surveillance System (NOHSS)			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ASTDD technical assistance will be requested to assist in developing a survey design to acquire a representative sample of Montana third graders using BSS.

New forms and guideline manuals incorporating suggestions will be developed.

HRSA SOHCS grant funds will be utilized to contract with dental hygienists to conduct a representative sample of third grade children in two regions of Montana in schools that offer free/reduced lunch programs.

Data will be compiled and utilized in reporting performance measure data, inclusion of data for the National Oral Health Surveillance System (NOHSS), and needs assessment activities and reports.

Free/reduced school lunch data was requested from the Office of Public Instruction to assist in targeting 30 schools for participation across Montana.

27 of 30 participating schools contacted prior to the end of the 2004/2005 school year have agreed to participate in the sampling. Three additional schools have been contacted and are expected to participate.

HRSA SOHCS grant funds are being utilized to train dental hygienists contractors in August 2005 to conduct a representative sample of third grade children in regions of Montana beginning in September 2005 and ending by April 1, 2006.

c. Plan for the Coming Year

Controlled sample data will be analyzed by the MCH Epidemiological Statistician, compiled into a report, and utilized in reporting performance measure data and needs assessment activities and reports.

Dissemination of the report will include all key stakeholders and partner organizations including members of the Montana Oral Health Coalition, local public health and tribal health offices, and participating schools.

Data will be submitted to CDC on behalf of Montana for inclusion in the National Oral Health Surveillance System (NOHSS).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	4.9	4.8	4.7	4.6
Annual Indicator	9.1	5.9	5.4	4.3	6.0
Numerator	17	11	10	8	10
Denominator	186130	186130	186130	186130	167463
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.5	4.5	4.4	4.4	4.3

Notes - 2004

Data of deaths of children taken from the 2003 annual statistical accounting of deaths by reason. The category identified was for children under 14 that died in a motor vehicle accident.

The population is the July 1, 2004 census data for all age cohorts obtained from the Montana Dept. of Commerce census information tables.

a. Last Year's Accomplishments

Department of Transportation and Healthy Mothers, Healthy Babies -
The Montana Coalition continue their efforts to improve effective seat belt use. Discussions with advocacy groups to reintroduce Graduated Drivers License legislation into the 2005 session (beginning in January 2005) are underway. Primary seat belt legislation is also being considered by some advocacy groups, as is legislation to outlaw open container laws.
DPHHS continued support for SAFE KIDS/Safe Communities local and regional coalitions through, at least, monthly contacts with the EMCS/IP Coordinator

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to support legislative efforts to improve safety via primary seatbelt laws				**X**
2. Pursue stronger DUI legislation				**X**
3. The Adolescent and School Health Coordinator will work with Joint Committee for Healthy Kids, Connecting For Kids and FICMR team to research strategies for further reducing alcohol-impaired driving			**X**	
4. Promote social marketing techniques to educate opinion leaders and the public about the causes of motor vehicle–related injuries and about effective personal safety practices			**X**	
5.				
6.				
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9.				
10.				

b. Current Activities

Legislative support, using FICMR data, and death record data is used to support the need for legislative changes addressing seat belt use, open container laws, and graduated drivers license legislation. Legislature passed SB 104, Graduated Drivers License program; SB 38, Double Fine in School Zones; SB 487, School Bus Safety law: SB 80 Open Container Law. Continued team membership on the ambulance/emergency room/payment feasibility data linkage project.

The Adolescent and School Health Consultant became member of the State FICMR team

c. Plan for the Coming Year

Continue to support legislative efforts to improve safety via primary seatbelt laws; Pursue stronger DUI legislation; The Adolescent and School Health Coordinator will work with Joint Committee for Healthy Kids, Connecting For Kids and FICMR team to research strategies for further reducing alcohol-impaired driving; Promote social marketing techniques to educate opinion leaders and the public about the causes of motor vehicle--related injuries and about effective personal safety practices.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	72	71	72	73	74
Annual Indicator	69.4	87.2	70.2	70.9	74.0
Numerator	9458	9532	9705	9755	8486
Denominator	13629	10934	13823	13759	11464
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74.5	75	75.5	76	77.1

Notes - 2002

/2004/ We do know that the 2001 figures concerning breastfeeding data are questionable. On examination, the fields which should contain the breastfeeding data were blank in the state office database. In other words, the information was not uploaded to the system. There may also have been a number of records with incorrect information if they were not updated. The information appears to be present in the local agency databases. The absence of or error in data could have been caused by a corruption in a file either at the local agency level or during uploading. We decided to just allow the system to overwrite the records as they were updated (normal process) rather than attempt to locate and fix all of those with missing or incorrect data. //2004//

Notes - 2004

Total number of WIC children under aged two is denominator

Number of WIC infants ever breastfed is numerator

a. Last Year's Accomplishments

a. Last Year's Accomplishments
Training of WIC staff through conferences and a pre-session at the Spring Public Health Meeting was performed. Updated local agency references with Thomas Hale's Medications and Mother's Milk. Continued distribution of manual breast pumps and piloted several electric breast pump projects.

The Montana WIC Program has awarded funds for a peer breastfeeding counselor program. Two state staff attended training to determine if a program is feasible in Montana. The pilot electric breast pump projects were so successful that expansion to a total of 25 counties/reservations was accomplished. The State Breastfeeding Coordinator attended the Breastfeeding Management and Support Services Seminar in Denver. New breastfeeding educational materials were purchased.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to distribute manual and electric breast pumps.			X	
2. Continue to provide early pre-hospital breastfeeding edutaion			X	
3. Purchase breast feeding reference book for pregnant womern and new breast feeing mothers			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A chapter was added to the Montana WIC State Plan focusing on breastfeeding to emphasize its importance and includes policies for promotion and support. It contains expanded information. Two Native American Breastfeeding Posters were developed and distributed to all clinics. Received a Peer Breastfeeding Counseling (PBC) grant. Awarded Ravalli County WIC the Pilot Peer Breastfeeding Counseling Grant; and sent three staff from Ravalli County to attend training on peer breastfeeding counseling in Denver offered by USDA in conjunction with Best Start.

PBC funds are also being used to plan a week-long breastfeeding conference for select WIC staff. Breast pumps and breastfeeding education materials continue to be purchased by the State Office and disseminated to local programs. Distributed information on a free breastfeeding poster and pamphlet from the National Breastfeeding Awareness Campaign; updated information on breastfeeding recommendations from the American Academy of Pediatrics; pertinent news and information/studies on breastfeeding; and information on free breastfeeding pamphlets in Spanish.

Lactation Education Funds were used to purchase lactation self-study modules, to provide another avenue of training for local WIC Program staff. Activities performed by local programs during World Breastfeeding Week were shared. Sponsored the IBCLC registration of two local agency staff.

c. Plan for the Coming Year

"The Lactation Counselor Certificate Training Program--A comprehensive breastfeeding management Course" will be held in August 2005. Staff completing the training will receive a Lactation Counselor certificate.

Continue to purchase and distribute breast pumps. Various breastfeeding education materials will be reviewed by committee and purchased to provide standardized breastfeeding education materials, including in other languages and targeted to other racial groups.

Evaluate the use of the lactation self-study courses.

Evaluate the Pilot Peer Breastfeeding Counseling Grant and expand to other local programs if successful.

Encourage local programs to participate in World Breastfeeding Week and to share their activities.

Upon approval from USDA, disseminate the State Plan chapter on breastfeeding.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	33	80	98	98	98
Annual Indicator	78.3	83.3	90.1	90.0	92.8
Numerator	8459	9111	9810	10144	10563
Denominator	10809	10935	10886	11276	11378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

a. Last Year's Accomplishments

In calendar year 2004, 100% of the birthing facilities provided newborn hearing screening information. Ninety-eight percent (98%) of all live births in Montana occurred in birthing facilities (as opposed to home, doctor's office or "other" locations). Of those born in birthing facilities, 89% were reported as receiving hearing screening prior to birthing facility discharge. Only 2% of the newborns were reported as not completing their initial screenings on

an out-patient basis. This number is likely an overstatement of lack of completion of screening due to the fact that one screener for a large service area had not been reporting screenings that resulted in normal hearing determinations, but rather had only referred newborns with abnormal results for audiologic diagnosis. Our data reporting system includes outcome data on five babies with confirmed hearing loss in 2004. It is not yet known if this is an accurate number because not all audiologists reported their results in the same manner during calendar year 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide TA to birthing facilities and audiologists in their use of HI*TRACK reporting system				X
2. Track newborn hearing screening and audiologic assessment results from the HI*TRACK system				X
3. Electronically refer infants with diagnosed hearing loss to the Montana School for the Deaf and Blind, which has statutory responsibility for tracking children with hearing impairments from birth through 21 years of age.		X		
4. Continue to work with CSHCN, Part C, MSDB and advisory council to assure appropriate, efficient continuum of services				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

By July 2005, birth certificate data will be linked with the hearing screening data to ensure population-based surveillance. Children with an assessed hearing loss will then be entered into the CSHCH data system, which is directly accessed by both CSHCH staff at the state and the Montana School for the Deaf and Blind (MSDB). State program Part C managers have decided not to participate in this electronic linkage for the time being, although a new Part C Coordinator has been hired and may reassess this position. MSDB is creating memoranda of agreement with individual Part C contractors to coordinate referrals and local services.
The state has combined heelstick and newborn hearing screening monitoring and reporting functions within one .50 FTE position. This position reinforces with birthing facilities, midwives, pediatricians and OB/GYN service providers the importance of hearing screening as part of the standard of care for newborns along with metabolic screening. State-supplied technical support for ensuring the validity of the heelstick screening is provided by the Montana Public Health Laboratory. State support of the initiation, followup and reporting of both heelstick and hearing screening by the birthing facilities will be provided by the newborn screenings monitor/educator in the MCH Data Monitoring Section. Management of the birth defects registry for Montana's annual birth cohort of <12,000 will occupy the other .50FTE of the time of this position. Epidemiological support will be provided by other staff in the same Bureau.

c. Plan for the Coming Year

The NBS/BDR position will provide or ensure the provision of programmatic technical assistance to the birthing facilities and the audiologists to improve the rate of screening and reporting of audiologic assessments. With early discharge from hospitals, out-patient screening requires an increased focus. Work will continue with state program partners in the CSHCN program, IDEA Part C, the Office of Public Instruction, and the Montana School for the Deaf and Blind and with the UNHSIT Advisory Council to assure provision of quality intervention services for infants with identified hearing loss. The program will continue to contract for vendor assistance to birthing facilities in the use of the HI*TRACK reporting/data management system. The program plans to engage a facilitator team to work with the program and the advisory group to focus on the statutory charge of the advisory group and to generate consensus recommendations from the group for the statewide UNHSIT continuum of services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	11	17	16	16
Annual Indicator	18.0	18.0	17.0	9.6	9.6
Numerator	46340	46340	39207	22000	22000
Denominator	257440	257440	230630	230062	230062
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	9	9	9	9

a. Last Year's Accomplishments

The results of the Montana Statewide Study of the Uninsured State Planning Grant conducted by the Department of Public Health and Human Services found that 17% of Montana children age 0-18 were uninsured. The information was obtained through research, surveys, focus groups, key informant interviews and public meetings. There are 22,000 Montana children who live in households with incomes at or below 150 percent of the Federal Poverty Level. Approximately one-third of these children may be eligible for Medicaid. Therefore, approximately 15,000 children could be eligible for CHIP.

CHIP provided health insurance coverage for 15,281 Montana children in FFY 2004. The annual CHIP Enrollee Survey indicates a high level of satisfaction with CHIP. The areas of focus include the following: Customer Service, Child's Personal Provider, Child's Health Care, Child's Dental Care, Timeliness of Care, and Provider Communication. We strive to maintain and improve our network of CHIP providers to ensure access to health care for children with CHIP. At the end of FFY 2004 there was a CHIP provider

network of 252 dentists (5% increase) and 3,493 physicians, allied health providers and hospitals (6% increase) throughout Montana. This provider network continues to grow steadily and ensures access to children with CHIP coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Acquire state and local funds to match federal funds and continue to insure Montana childres				
2. Refer 100% of children not elibible for CHIP to other appropriate programs or plans				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

At the end of FFY 2004 there were 10,885 children enrolled and 126 on the waiting list. We currently have about 10,900 children enrolled and more than 500 children on the waiting list. CHIP continues to receive solid support from Governor Schweitzer, the legislature, families with CHIP coverage and the general public.

CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. We provide information about the Caring Program for those children found to be over income for CHIP. CHIP sends information about the Primary Care Association members (Community Health Centers, NHSC sites, Migrant and Indian Health clinics) to all families who apply for CHIP.

We also provide information and referrals to Blue Care, Montana Youth Care and Montana Comprehensive Health Association. Callers to the Department's Family Health Line can also receive resources and referrals to private, low-cost health insurance and other resources in their communities.
In conjunction with Medicaid staff, we conduct regular visits to each Native American tribe in Montana to provide information and answer questions regarding CHIP and Medicaid.

c. Plan for the Coming Year

CHIP will receive an increase in state funds effective July 1, 2005. These funds will be matched with federal funds and enable us to enroll approximately 3,000 additional children this year. I n addition, we will be increasing mental health benefits for CHIP children who have a serious emotional disturbance (SED).

We will focus on providing information to CHIP families about the importance of preventive

care.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	95	95	95
Annual Indicator	90.0	98.1	86.6	86.7	88.7
Numerator	48111	52585	55526	46369	57700
Denominator	53457	53594	64089	53457	65079
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2004

The trend analysis for 2000-2004 revealed continued decreases in the percent of children receiving services, and the true percentage for 2010 at approximately 75%. MCH has limited control over this program and subsequent performance measurement, including the actual yearly indicators and future projections.

a. Last Year's Accomplishments

Percent of children receiving services paid for by Medicaid continues in the high 90%. The performance measure is an indicator of a single service only, however, and does not measure adqequacy of the services overall. The EPSDT effort continues to inform families of periodicity schedules for children's preventive health services through mailings and outreach efforts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Send-out reminder letters and magnets for well child check ups and immuizations on the child's birthday			X	
2. re-write provider manuals to more clearly detail explanations for well child screens and other EPSDT components				X
3. re-write client education materials to more clearly explain EPSDT				X
4. Re-do telephone outreach script to cover EPSDT in more detail				X
5. implement flouride varnish in physician and midlevel offices			X	

6. implement provider profiling and TA to providers to improve performance			X	
7.				
8.				
9.				
10.				

b. Current Activities

Efforts to maintain existing optional Medicaid services will be a major consideration in the upcoming legislative session. Medicaid redesign plan will be an agenda item in the legislative session.

c. Plan for the Coming Year

EPSDT outreach includes reminder letters sent to children who should have a well child check per the period schedule. Include with this is a magnet with the periodicity schedule.

Newsletter article continue to have information re well child visits and the periodicity schedule

Outreach script continues to have information re well child visits

Implemented the Nurse First program which includes a 24 hour a day 7 day a week nurse advice line.

Still designing the client utilization reports and hope to have it up and running this fall.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.0	1.2	1.1	1.0	1.1
Numerator	110	125	120	115	123
Denominator	10809	10814	10886	11276	11526
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.8	0.8	0.8	0.8	0.8

a. Last Year's Accomplishments

January 15, 2004 conducted a meeting by teleconference for all MIAMI reservation projects to discuss successful interventions for high risk pregnancy clients, compliance and future plans

March 24, 2004--DPHHS oral health consultant provided information about the link between severe periodontal disease and preterm labor to 35 FICMR coordinators/Public Health Nurses

March 24, 2004--Provided March of Dimes Prematurity Prevention materials and education to FICMR coordinators/Public Health Nurses

May 2004--Supported March of Dimes "Walk America" Prematurity Prevention campaign by providing information in the workplace as well as to the local FICMR coordinators.

May 2004--Provided "prenatal smoking cessation" education at the Spring Public Health Conference

May 2004--March of Dimes Prematurity Prevention materials provided at the Spring Public Health Conference

Distributed 3,500 toothbrushes with prematurity prevention information attached to WIC Clinics, Healthy Mothers Healthy Babies, FICMR coordinators, and to a reservation prepared childbirth class

Recruited 3 reservations to FICMR review process for a total of 7 of 7 reservations now participating

Public Health Home Visiting program has been revamped via RFP and contracts are being finalized to 19 counties and reservations. Initiated a work group of Public Health Home Visitors to revise the identification criteria high risk for High Risk Pregnant women to comply with current best practice standards.

Published the second Fetal, Infant and Child Mortality Review report, which addressed prematurity and low birth weight risk factors.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide prematurity prevention outreach to FICMR coordinator network			X	X
2. Continue to utilize and disseminate March of Dimes Prematurity Prevention materials			X	
3. Initiate discussion with the Indian Health Service Maternal Child Health Nurse Consultant on prematurity prevention outreach for the Native American population				X
4. Discuss possible link between prematurity and methamphetamine use and prematurity and obesity with FICMR coordinators, and consider tracking on FICMR reports.				X
5. Reissue an RFP to continue and expand Public Health Home visiting programs.				X
6. Provide two training opportunities for PHHV sites.				X

7.				
8.				
9.				
10.				

b. Current Activities

Continue to provide prematurity prevention outreach to FICMR coordinator network
Continue to utilize and disseminate March of Dimes Prematurity Prevention materials

Will initiate a discussion with the Indian Health Service Maternal Child Health Nurse Consultant on prematurity
prevention outreach for the Native American population

Provide standardization and training of all Public Health Home Visiting projects

Provide educational outreach regarding low birth weight prevention activities for the workplace.

01/04/05--Participate on the Drug Endangered Children Task Force, which includes prenatally affected children

04/05--Participate on the Children's Environmental Health Committee, addressing prenatal exposures to environmental contaminants.

04/31/05--Participated in the Florida AHEC Network teleconference on Helping Pregnant Women Quit Smoking.

04/21-22--Attended Montana Mental Health Association Conference on Critical Incidents and Trauma Response

April 2005--Initiated contact with the Medicaid program, eliciting support and buy in for prematurity prevention.

April 2005--Supported March of Dimes "Walk America" Prematurity Prevention campaign by posting educational materials in the workplace and supporting participation by DPHHS employees

May 2005--Completed development of the revised High Risk intake outcome for implementation in the PHDS system

May 2005--Provided education on the "Culture of Poverty" to Public Health Nurses at the Spring Public Health conference

05/26/05--Cultural Competence Training provided by the Center for Cultural and Linguistic Competence/Georgetown University to FICMR coordinators

05/05--Facilitated a presentation on Drug Endangered Children at the Spring Public Health Conference

05/05--Working collaboratively with the neonatologist at Benefis East hospital, distributed Prematurity Prevention Kits for educational outreach to all FICMR coordinators

06/14/05--Provided NCAST Maternal Mental Health training for 25 public health home visitors

c. Plan for the Coming Year

Continue to provide prematurity prevention outreach to FICMR coordinator network

Continue to utilize and disseminate March of Dimes Prematurity Prevention materials
PBS
Initiate discussion with the Indian Health Service Maternal Child Health Nurse
Consultant on prematurity prevention outreach for the Native American population

Discuss possible link between prematurity and methamphetamine use and prematurity and obesity with FICMR coordinators, and consider tracking on FICMR reports.

Reissue an RFP to continue and expand Public Health Home visiting programs.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	16.5	11.8	11	10.2	9.5
Annual Indicator	11.2	12.6	14.0	16.9	16.9
Numerator	8	9	10	12	12
Denominator	71310	71310	71310	71149	71149
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Notes - 2003

Death information is NOT AVAILABLE from our Office of Vital Statistics at this time. A data system upgrade data conversion process resulted in loss of death statistics for 2003. These data will be updated in next year's MCHBG Report submission.

Notes - 2004

Due to small numbers affecting the variability of the indicators and subsequent projections, the following procedure was used to correct the small number problem for this performance measurement.

The mean number of youth suicides from 2000 to 2004 was 14.3 per 100,000. Given a 1/3 reduction in suicides with the onset of grant money applied for in 2005 (not yet awarded), the expected rate would be approximately 10 deaths per 100,000 youth. If the grant is not awarded, the average mean rate of 14.3 would be more realistic due to limited current funding for the program ($50,000).

a. Last Year's Accomplishments

Four gatekeeper trainings have been conducted throughout Montana.
Governor Martz allocated $50,000 for teen suicide prevention; four mini-grants of $10,000 for community based suicide prevention were allocated and one state wide assessment conducted.

Met with Margene Tower of IHS, several completed suicides, state and tribes working on community plans, training, and more development including safety plans and working with survivors.

Thom Fanning has spearheaded a gatekeeper in the schools in order to bring contagion under control.

Native American Youth Suicide Prevention Conference was held in Billings, using the GONA model.

Continuing to look at strengthening web-site and building links with the 211 health communication

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to review all youth suicide by FICMR teams at the state and local level				X
2. Fund, and review, 5 new grants to communities for youth suicide prevention activities				X
3. If funded follow through on developing RFP's for up to 15 communities for Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention grant				X
4. Continue to support QPR and identify and encourage other best practice methods to prevent both fatal and non-fatal suicidal behaviors among youth aged 10-24			X	X
5. Work with CHIP and Medicaid programs, and develop private partnerships to Improve access to, and availability of appropriate prevention services for vulnerable youth				X
6. Release at least 1 press release in Montana's media to increase awareness that youth suicide is a Public Health problem that is preventable			X	
7. Continue attendance at SOCC and Connecting For Kids committees to promote and Increase access to, and linkages with Mental Health and Substance Abuse Services				X
8. Work with schools through (Joint Committee for Healthy Kids), Mental Health (Systems of Care Committee), Juvenile Justice and Children with Special Health Care Needs (Connecting for Kids) to promote youth				X

suicide prevention across the systems				
9.				
10.				

b. Current Activities

Current Activities:
Ongoing activities: in 2004.
1) Four $10,000 mini-grants have been funded and are implemented. Reports due by June 15th.
2) CACH received $50,000 in Public Health Block Grant Carry-over funds. Five new or continuing sites in local communities will be awarded mini grants for youth suicide prevention projects.
3) May 2005 Montana Strategic Suicide Prevention Plan is updated with youth specific language
4) May 2005, FCHB applied for Garrett Lee Smith Funds: Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention.
5) If above funding is received, DPHHS will identify specific criteria for and develop RFP's for up to 15 community grants for youth suicide prevention, as per Cooperative Agreements grant application
6) Adolescent and School Health Consultant was added as member of the state FICMR team
7) Write and disseminate a report on the findings of the four community grants and the community needs assessment.
8) Supported QPR training in communities through the Governor's Initiative on Youth Suicide Prevention

c. Plan for the Coming Year

Continue to review all youth suicide by FICMR teams at the state and local level
Fund, and review, 5 new grants to communities for youth suicide prevention activities
If funded follow through on developing RFP's for up to 15 communities for Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention grant
Continue to support QPR and identify and encourage other best practice methods to prevent both fatal and non-fatal suicidal behaviors among youth aged 10-24
Work with CHIP and Medicaid programs, and develop private partnerships to Improve access to, and availability of appropriate prevention services for vulnerable youth
Promote awareness that youth suicide is a Public Health problem that is preventable through offering training at professional conferences, (MPHA, Montana Spring MCH Conference, Montana Chapter of AAP and FP.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	81	85	86	86.5	90

Annual Indicator	87.3	88.8	75.8	88.7	81.3
Numerator	96	111	91	102	100
Denominator	110	125	120	115	123
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90

Notes - 2004

Trend analysis from 2000 to 2004 indicated an actual decrease in the percent of very low birth weight deliveries, with a 2010 projection of 75.12%. Projections were reset to accommodate for that downward trend in deliveries.

a. Last Year's Accomplishments

Sustaining the Fetal, Infant and Child Mortality Review program.
Providing ongoing support to the community level FICMR coordinators
Providing prematurity prevention materials from the March of Dimes to the FICMR coordinators
Public Health Home Visiting program has been revamped via Request For Proposal and contracts are being finalized to 19 counties and reservations
Years 2001 and 2002 FICMR data being analyzed by contracted MCH epidemiologist
Working on second statewide report of fetal, infant and child deaths with assessment of preventable deaths and community level interventions
Provided prematurity prevention materials from the March of Dimes to the FICMR coordinators
Participated in Medicaid Targeted Case Management work group to create or revise policy to improve case management delivery to high risk pregnant women and children with special health care needs. Also worked on development of a training manual so providers will have an accurate and user-friendly resource.
Provided on site training for three new PHHV sites.
Provided site visits to assist PHHV programs in providing services and to assess for problem areas.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provide continued PHHV training on assessment tools and interventions at the fall Public Health Conference				**X**
2. Continue to revise and implement changes in the PHDS to further enhance data collection and retrieval				**X**
3. Reissue an RFP to continue and expand Public Health Home visiting programs				**X**
4. Provide two training opportunities for PHHV sites.				**X**
5. Site visits to assist PHHV programs in providing services and to assess for problem areas				**X**
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Will provide "Kicks Count" education to public health nurses, including public heath home visitors
Accomplish standardization and training of all Public Health Home visiting projects
Will coordinate a discussion involving two of Montana's three perinatologists about effective prematurity prevention outreach and a regional transport system for at risk pregnant women byJune 30, 2005. 29 community level teams who are collectively reviewing deaths for 52 counties and seven reservations are completing FICMR reviews. These teams assess prematurity issues leading to the death of an infant, and initiate changes or make recommendations as appropriate
February 2005--In collaboration with the public health data system (PHDS), convened a work group to get input on changes in the PHDS to improve tracking and monitoring maternal risk factors and outcomes.
Accomplished standardization of Public Health Home Visiting Program and provided training to all Public Health Home Visitors .

c. Plan for the Coming Year

Provide continued PHHV training on assessment tools and interventions at the fall Public Health Conference
Continue to revise and implement changes in the PHDS to further enhance data collection and retrieval
Reissue an RFP to continue and expand Public Health Home visiting programs
Provide two training opportunities for PHHV sites.
Site visits to assist PHHV programs in providing services and to assess for problem areas.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	84	84.5	85	85.5
Annual Indicator	83.0	82.5	83.3	84.2	82.8
Numerator	8967	8922	9067	9496	9423
Denominator	10809	10814	10886	11276	11378
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	86.5	87	87.5	87.5

Notes - 2004

Trend analysis was completed for this measurement.

a. Last Year's Accomplishments

Ongoing consultation to FICMR coordinators regarding outreach to pregnant women

Public Health Home Visiting program has been revamped to focus on the pregnant women with the greatest needs and contracts are being finalized to 19 counties and reservations.

Conducted a meeting by teleconference for all MIAMI reservation projects to discuss successful interventions for high risk pregnancy clients, compliance and future plans

Supported March of Dimes "Walk America" Prematurity Prevention campaign by providing information in the workplace as well as to local FICMR coordinators.

Initiated a work group of Public Health Home Visitors to revise the identification criteria for High Risk Pregnant women to comply with current best practice standards.

Provided on-site training for three new PHHV sites.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Reissue an RFP to continue and expand Public Health Home visiting programs			**X**	
2. Provide two training opportunities for PHHV sites				**X**
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Organize a teleconference among Public Health Home Visitors regarding successes, challenges, and ideas for identifying and enrolling pregnant women into early prenatal care.

Using Pregnancy Risk Assessment Survey (PRAMS) data design interventions geared to ascertainment of early prenatal care.

Supported March of Dimes "Walk America" Prematurity Prevention campaign by posting educational materials in the workplace and supporting participation by DPHHS employees.

Completed development of the revised High Risk intake outcome for implementation in the PHDS system Provided NCAST Maternal Mental Health training for 25 public health home visitors

c. Plan for the Coming Year

Reissue an RFP to continue and expand Public Health Home visiting programs. Provide two training opportunities for PHHV home visitors and provide an opportunity to share information on successful interventions to enroll women into early prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of unintended pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	66.7%	50%	52	54	52
Annual Indicator	63.7	59.3	64.8	66.1	64.6
Numerator	984	1159	1261	1189	1200
Denominator	1545	1953	1946	1799	1858
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	62	62	61	61

Notes - 2003

The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

Notes - 2004

The denominator is total Title X clinic clients. The numerator is the total of these clients with unintended pregnancies.

2009 Revised trend would be 60.6. We recognize challenges with decreasing this unintended rate, which is impacted by factors other than health care access.

a. Last Year's Accomplishments

/2005/Unintended pregnancy prevention remains one of sixteen priorities in the

Montana Health Agenda, a road map for health service and program action, particularly for the Department's Health Policy and Services Division. This priority section outlines the Department's goal to decrease unintended pregnancy and lists specific objectives relating to unintended pregnancy.
/2005/The WMHS maintained contracts with local family planning clinics to assure access to comprehensive reproductive health care for men and women of reproductive age. Additional special initiative funds provided local clinics with funding for male clinics, information, education and communication projects, client family and community involvement, addressing health disparities in reproductive health, and providing efficacious contraceptives to low-income clients.
/2005/The service expansion and other special initiative projects have lead to an increase in the number of unduplicated clients served by local clinics. In SFY 2003, the number of clients served increased to 28,684. It is estimated that Title X family planning services prevented approximately 18,480 unintended pregnancies, including 2,618 abortions, during SFY 2003.//2005//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with clinics for FP services to at least 29,500 clients at risk of unintended pregnancy.				
2. Ensure that 97% of female FP clientes using contraception do not experience an unintended pregancy.				
3. At least 69% family planning clinic clients will e at or below 150% of federal poverty level.				
4. Fund FP clinics for efficacious contraceptives for low-income clients (below 250% of poverty.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/The WMHS continues to distribute outreach materials to county Offices of Public Assistance, community action programs, Healthy Mothers, Healthy Babies, local MIAMI Projects, WIC offices, local Breast and Cervical Health Program sites, and Indian Health Services. Family planning programs also receive outreach materials and distribute them to clients and community partners. Outreach materials include the 24-hour toll-free hotline number so clients can find the nearest Montana Family Planning Clinic.
/2005/The WMHS provides fact sheets on the topics "What is Family Planning?" "The Benefits of Family Planning Activities," and "Accomplishments of the State Family Planning Program." These fact sheets are used in conjunction with the family planning

display and are distributed to local Title X clinics. Department staff also uses the fact sheet to educate legislators on family planning issues.
/2005/ Legislation passed in 2001 allows pharmacists to have collaborative agreements with prescribers to initiate drug therapy. Formal ECP training for pharmacists is

included in continuing education offered by the University of Montana School of Pharmacy. Currently the Community Health Center in Livingston Montana employs a pharmacist who provides ECPs through a collaborative agreement with a physician. The Nurse Consultant will continue to monitor, support, and promote the provision of ECPs by pharmacists through the use of collaborative agreements when opportunities arise.
/2005/ A referral system has been developed for rural agencies that do not have capacity to provide IUD insertions to refer to larger agencies for IUD insertions. This system increases the availability of IUDs for low-income women. The IUDs are provided through the federal regional efficacious contraceptive funds
/2005/During SFY 2004, the WMHS received special initiative funding for local Male Adolescent Clinics; for Information, Education and Communication (IEC) projects; for Client, Family and Community Involvement (CFC); for Family and Intimate Partner Violence and for Efficacious Contraceptives. Local male clinics use teen male interns to reach an increased number of male clients. The IEC projects fund local clinics to increase awareness of family planning services and to increase knowledge on reproductive health. The CFC projects focus on outreach to special needs populations, parents and school districts to increase awareness and support for family planning services. Research shows that victims of family violence are at increased risk of unintended pregnancy. Through special funds for highly effective contraceptives, including emergency contraceptives, the WMHS focuses on reducing the teen pregnancy rates as well as the teen birth rate.//2005/

c. Plan for the Coming Year

/2005/During the coming year, the WMHS plans to address unintended pregnancy through continued contracts with its local family planning clinics providing comprehensive reproductive health care in 29 locations to residents of all 56 Montana counties. Because low-income clients are at increase risk of unintended pregnancy, the WMHS will continue to offer comprehensive family planning services targeting lowincome men and women.
/2005/Through training and educational activities, the WMHS plans to assist local family planning programs provide quality medical, clinical counseling and education services for all clients. A training needs assessment will be distributed to local family planning clinics to develop educational goals and training programs. Such training improves the service and quality of care in reducing unintended pregnancies among clients of local family planning programs.
/2005/The WMHS will provide health education materials on unintended pregnancy to local programs and other public health partners. These materials will be updated to reflect the increased availability of information in an electronic format. The health educator will continue to investigate on-line resources and other sources of current information that includes unintended pregnancy prevention.

/2005/ The WMHS has applied for special initiative funding for Male Adolescent Clinics; Male Reproductive Health; Information, Education and Communication (IEC) projects; Client, Family and Community Involvement. Each of these projects addresses the issue of unintended pregnancy within specific populations among family planning clients. Male clinic projects will focus on male responsibility in reducing unintended pregnancy. Research shows that victims of family violence are at increased risk of unintended pregnancy. The Client, Family and Community Involvement projects focuses on family planning services to clients who have difficulty accessing Title X services.
/2005/ The WMHS will continue to provide special funding for efficacious contraceptives to local family planning clinics. These high-cost and highly effective contraceptives will be provided to low-income clients who fall at least below 250% of the federal poverty level.//2005//

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2%	98%	98	98	98
Annual Indicator	1.6	98.3	96.9	97.2	97.3
Numerator	177	10668	10552	10959	11070
Denominator	10862	10857	10886	11276	11378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	98	98	98	98

Notes - 2002

/2004/ In 2001 we changed the reporting requirement we now are reporting the % of women who abstained from alcohol use instead of reporting the percent who used alcohol . //2004//

a. Last Year's Accomplishments

/2005/ Montana continues to promote a no alcohol use policy for pregnant women and/or women considering pregnancy. Community based efforts continue to offer education and support through the public health home visiting project (AKA MIAMI). Montana conducted a Request for Proposal for public health home visiting services in spring of 2004. Contracts for new public health home visiting services in 19-20 communities are presently being negotiated. Alcohol use, abuse and/or use/abuse by individuals in the household are risk indicators which qualify women for public health home visiting services by a team of professionals (nurse, social worker and dietician) and an optional paraprofessional member. Minimum standards for home visiting services are established in the new contracts, which target high risk pregnant women and their infants. Montana was awarded a FASD grant from the FASD Center for Excellence

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Issue an RFP to institute a lay home visitor intervention to 4-8 PHHV sites for the prevention of FASD				**X**
2. Revise FASD prevention curriculum to incorporate needs assessment				

results				X
3. Provide training for Lay home visitors and PHHV staff at the selected intervention sites				X
4. Continue the FASD Advisory Council meetings quarterly			X	X
5. Site visits and conference calls to assure successful FASD intervention launching and maintenance			X	X
6. Reapply for FASD subcontract for prevention, identification, and treatment of FASD				X
7.				
8.				
9.				
10.				

b. Current Activities

/2005/ Training provided for 35 public health home visitors from the newly established public health home visiting contractors on ACOG's domestic violence screening tool, the 4P's alcohol, drug, and tobacco screen, the Life Skills Progression assessment, targeted case management, and data collection. Reporting of findings was mandated using the public health data system (PHDS) for county program sites and via hard copy reporting for tribal contractors. 100% of newly contracted sites are responsible for assessing for alcohol use in pregnant women, and for case management which includes referral to substance use programs and monitoring of compliance. Training provided on Maternal Mental Health to 23 PHHV professionals. Regularly facilitated reflective supervision conference calls with public health home visitors to improve intervention skills. A needs assessment was conducted to determine needs and best interventions for women at risk of alcohol use in pregnancy including four focus groups of at risk public health consumers PHHV consultant attended the FASD State Systems Building Conference and presented a poster session and moderated two breakout sessions on FASD prevention. With the assistance of a statewide FASD Advisory Council, four deliverable reports (Kick Off meeting, Work Plan and Time line for Task Force and Needs Assessment, Needs Assessment Findings, and Proposed Strategy Report) and a FASD RFP will be submitted to Northrop Grumman for FASD subcontract for prevention, identification, and treatment of FASD, to comply with the current FASD subcontract and to plan for the coming year's intervention.

c. Plan for the Coming Year

Issue an RFP to institute an intensice case management model utilizating adding a ay homevisitor to the professional team as an intervention to 4-8 Public Health Home Visiting (PHHV)sites for the prevention of Fetal Alcohol Spectrum Disorder (FASD). The FASD project prevention curriculum from the Four State FAS Consortium will be revised to incorporate Fetal Alcohol Spectrum Disorder statewide needs assessment results. Several trainings for Lay home visitors and PHHV staff at the selected intervention sites will be offered to funded FASD Prevention Sites. The FASD Advisory Council will continue to meet bimonthly to assist with the planning and implementation of the FASD Project. Site visits and conference calls to participating projects will assure that both PHHV and FASD intervention launching and maintenance will be successful. Prepare a proposal for the next round of funding for the FASD subcontract for prevention, identification, and treatment of FASD through the FASD Center for Excellence.

State Performance Measure 4: *Percent of "WIC" infants who are breastfed at six months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	39%	41%	42	43	44
Annual Indicator	25.5	33.6	25.7	31.8	25.7
Numerator	3471	4574	3548	4381	2945
Denominator	13629	13624	13813	13759	11464
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	45	46	47	48	49

Notes - 2004

National WIC goal is 50% by 2010. Trend analysis suggests percentage may be going down, however.

a. Last Year's Accomplishments

/2005/Accomplishments in 1999: In 1999 WIC provided numerous opportunities for local agency staff to receive training in breastfeeding promotion and support. WIC purchased a number of nutrition and breast-feeding references to accompany the Competency Based Training Program modules and to update information.
/2002/ Indicator data for 2000 is highly suspect due to a problem with the automated system. The problem has not been completely resolved and infants entered into the system may have data missing from one of the fields used to determine breast feeding status.
Accomplishments in 2000: A number of staff received scholarships to attend WIC Nutrition: Going for the Gold, the National Association of WIC Directors Nutrition and Breastfeeding Conference. The Regional Dietitian Project was started. Currently two contracts were awarded to provide services to seven WIC programs and their satellites.
Accomplishments in 2001: The Regional Dietitian Project continued. Began 4 pilot projects to promote breastfeeding. Breastfeeding cues magnets distributed to local agencies. 13 local agency staff attended the 2nd Annual Mother-Baby Symposium "Breastfeeding in the 21st Century" in Missoula, MT.
Accomplishments for 2002: A breastfeeding conference with a nationally recognized speaker was held in Montana. A number of local agency staff attended the National Association of WIC Directors Nutrition and Breastfeeding Conference. Four pilot projects are ongoing in the state for a second year. Each project is addressing breastfeeding promotion and support in the community in a different way.
/2004/ Training of WIC staff through conferences and a pre-session at the Spring Public Health Meeting was performed. Updated local agency references with Thomas Hale's Medications and Mother's Milk. Continued distribution of manual breast pumps and

piloted several electric breast pump projects.//2005//
/2005/The Montana WIC Program has awarded funds for a peer breastfeeding counselor program. Two state staff attended training to determine if a program is feasible in Montana. The pilot electric breast pump projects were so successful that expansion to a total of 25 counties/reservations was accomplished. The State Breastfeeding Coordinator attended the Breastfeeding Management and Support Services Seminar in Denver. New breastfeeding educational materials were purchased.//2005//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue distribution of manual and electric breast pumps			X	
2. If funds available support local staff to obtain lactation consultant certificate			X	
3. Continue peer breastfeeding counselor pilot			X	
4. Evaluated peer breast feeing counsel- pilot			X	
5. If positive evaluation of peer breastfeeding counseling piolot expade project to new locations			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/A chapter was added to the Montana WIC State Plan focusing on breastfeeding to emphasize its importance and includes policies for promotion and support. It contains expanded information. Two Native American Breastfeeding Posters were developed and distributed to all clinics. Received a Peer Breastfeeding Counseling (PBC) grant. Awarded Ravalli County WIC the Pilot Peer Breastfeeding Counseling Grant; and sent three staff from Ravalli County to attend training on peer breastfeeding counseling in Denver offered by USDA in conjunction with Best Start. PBC funds are also being used to plan a week-long breastfeeding conference for select WIC staff. Breast pumps and breastfeeding education materials continue to be purchased by the State Office and disseminated to local programs. Distributed information on a free breastfeeding poster and pamphlet from the National Breastfeeding Awareness Campaign; updated information on breastfeeding recommendations from the American Academy of Pediatrics; pertinent news and information/studies on breastfeeding; and information on free breastfeeding pamphlets in Spanish. Lactation Education Funds were used to purchase lactation self-study modules, to provide another avenue of training for local WIC Program staff. Activities performed by local programs during World Breastfeeding Week were shared. Sponsored the IBCLC registration of two local agency staff. XXXXX//

c. Plan for the Coming Year

"The Lactation Counselor Certificate Training Program--A comprehensive breastfeeding management Course" will be held in August 2005. Staff completing the training will receive a Lactation Counselor certificate. Continue to purchase and distribute breast pumps. Various breastfeeding education materials will be reviewed by committee and purchased to provide

standardized breastfeeding education materials, including in other languages and targeted to other racial groups. Evaluate the use of the lactation self-study courses. Evaluate the Pilot Peer Breastfeeding Counseling Grant and expand to other local programs if successful. Encourage local programs to participate in World Breastfeeding Week and to share their activities. Upon approval from USDA, disseminate the State Plan chapter on breastfeeding.2005/

Of children under age 2 years (13,823) 2004 (13,759) 2005 (11,464)
Initiation of Breastfeeding is 70.2% (9,705) 2004 (9,755) 70.9% 2005 (8,486) 74%
Breastfeeding at 6 months of age 25.7% (3,548) 2004 (4,381)31.8% 2005 (2,945) 25.7%//2005//

State Performance Measure 5: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	30%	90%	95	95	95
Annual Indicator	33.9	76.8	91.1	88.0	62.3
Numerator	19	43	184	183	96
Denominator	56	56	202	208	154
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	95	95	95	95

Notes - 2002

/2004/ This performance measure has been changed because it isn't feasible for counties with small populations to establish their own teams. Counties are now allowed to partner with established FICMR review teams to accomplish their reviews. //2004//

/2004/ In 2002, Montana changed the reporting from the percent of counties participating in FICMR to the percent of deaths reviewed, which was a more accurate indicator of what we are trying to do. //2004//

/2004/ Data is for CY 2001. 2002 data will not be complete until 2004.

Notes - 2003

FICMR reviews are always performed retrospectively, and in most case 6-12 months after the deaths. 2002 data was recently finalized, with a noted change in the data as reported last year—Corrections are: Annual indicator-91%, Numerator-184, Denominator-202. 2003 data will

not be completed until January 2005. Annual performance objective of 95% may not be attainable because some child deaths are transfers from out of state facilities.

Notes - 2004

Provisional data until next report year.

a. Last Year's Accomplishments

/2005/Distributed second "mock case review" for inter-panel reliability to local coordinators. Reviews due December, 2004.
2001-2002 data being analyzed by contracted MCH epidemiologist
Second FICMR data report being developed
Prematurity prevention education to local coordinators on ongoing basis
Child abuse and neglect education scheduled for October, 2004
Page 65 of 77
Obtained youth suicide grant funding for implementation of youth suicide prevention efforts for three FICMR teams
Organizing a SIDS outreach campaign for all alternative schools, to be implemented October, 2004
Grief and bereavement education to local coordinators scheduled for October 2004
Department of Family Services scheduled to discuss child abuse and neglect reporting issues with local coordinators October 2004. //2005//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sustain FICMR program at the current level			X	
2. Continue focus on preventable prematurity			X	
3. Evaluate membership and governance of State FICMR team, and make changes as needed				X
4. Provide bereavement information to county FICMR coordinators				X
5. Analyze FICMR data for 2003 and 2004 and publish third statewide report			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/Sustain FICMR program at current level
Continue focus on preventable prematurity
Complete second FICMR report and disseminate statewide
Complete analysis of data from mock case review for inter-panel reliability//2005//

c. Plan for the Coming Year

/2006/ Sustain FICMR program at the current level
Continue focus on preventable prematurity
Evaluate membership and governance of State FICMR team, and make changes as

needed
Provide bereavement information to county FICMR coordinators
Analyze FICMR data for 2003 and 2004 and publish third statewide report

State Performance Measure 6: *Percent of facilities using standardized domestic violence screening tool as part of care assessment and planning.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	53%	54%	50	50	50
Annual Indicator	72.9	64.8	24.0	30.0	35.8
Numerator	35	35	12	15	19
Denominator	48	54	50	50	53
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	42	45	50	50

Notes - 2002

/2004/ The survey question for this data source changed in 2003. The 2004 report includes actual reporting of those using a standardized domestic violence screening tool. The 2003 survey reported clients screened for domestic violence. The advisory council will determine how to best address the question and/or increase standardized tool usage. //2004//

Notes - 2004

There is no standard tool in the field to collect this data so the data available is unreliable.

a. Last Year's Accomplishments

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Continue to encourage ongoing use of the ACOG Screen for Domestic Violence at all Public Health Home visiting sites.			**X**	**X**
2. Continue to encourage ongoing use of the Life Skills Progression tool at all PHHV sites			**X**	**X**

3. Implement county access to LSP data entry and retrieval through web based maternal child public health information network (McPHIN				**X**
4. Provide PHHV sites with training as to use of the McPHIN data entry and retrieval				**X**
5. Provide Targeted Case Management training for PHHV sites on all aspects of case management including the referral process for domestic violence.				**X**
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 7: *Percent of two year old children screened for lead.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	5%	20%	25	30	35
Annual Indicator	6.5	2.4	2.6	1.9	1.4
Numerator	1409	259	283	203	150
Denominator	21734	10798	10798	10798	10798
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	45	50	55	60

Notes - 2002

/2004/ Activities related to this Performance Measure have been suspended due to elimination of funding. The Bureau's Advisory Council will decide whether to change or discontinue this Performance Measure before the next report. //2004//

a. Last Year's Accomplishments

/2005/ The rate of screening in 2003 is less than 2%//2005//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Obtain annual Medicaid data on lead sceening for two-year old children in Montana				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/ Screening will continue for children who are Medicaid-eligible and for those with a payment source for the screening test. Without specific funding to support lead screening outreach, availability of payment source will determine lead screening.//2005//

c. Plan for the Coming Year

/2005/ Without specific funding to support lead screening outreach at the local level, leaad screening will continue to be limited to screening performed by providers for patients with public or private insurance.//2005//

State Performance Measure 8: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25.2%	30	31	32	33
Annual Indicator	23.9	23.0	23.7	23.4	23.5
Numerator	12754	12327	14123	14649	14707
Denominator	53457	53594	59578	62629	62629
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	23	23	23	23	23

Notes - 2004

Trend analysis for 2000-2004 suggests the projection rate for 2010 remains stable and constant.

a. Last Year's Accomplishments

To ease the administrative burden for providers, the Covered Services Section of the Medicaid Dental Provider Manual was updated to incorporate many provider suggestions in one convenient place including, dental fee schedule code reimbursement, all Medicaid covered CDT codes, CDT code allowed minimum and maximum age, and all service limitations per Code.
Montana Dental Advisory Board meetings were held to discuss provider requests to close existing codes and open new ones resulting in code actions per consensus of the Board.
Dental provider informational bulletins were included in the Medicaid Provider Claim Jumper monthly newsletter.
Personal meetings with individual and area provider groups regarding Medicaid concerns and program ideas
Updated Basic Dental Emergency Form with current codes.
Updated fee schedule to include minimum and maximum ages on covered codes.
Attendance at the National Oral Health Conference with DPHHS Oral Health Consultant, which provided a wealth of national oral health information

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Montana is continuing to explore several new ideas to address the access issue; one is the “Rent A Practice” for a day. This idea is to increase the number of Medicaid patients a provider is seeing in a low access area by paying a lump sum in additi			X	X
2. Attendance at the 2006 National Oral Health Conference to gain knowledge and participate in networking opportunities.			X	X
3. Ongoing participation as a member of the Montana Oral Health Coalition.			X	X
4. Continue ongoing collaboration with MDA and the Oral Health Consultant			X	X
5. Pursue avenues to increase participation of dental providers.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To ease the administrative burden for providers, the Covered Services Section of the Medicaid Dental Provider Manual continues to be updated to incorporate many provider suggestions in one convenient place.

Updated Basic Dental Emergency Form with current codes.
Updated fee schedule to include new July 1, 2005 CDT 5 codes and increased reimbursement rates.
Ongoing participation as a member of the Montana Oral Health Coalition including participation in the implementation of the State Oral Health Plan as it relates to Medicaid.
Coordination with the EPSDT Physician Guidance Workgroup to incorporate a new EPSDT manual into the physician manual and develop a website link for convenience.
Coordination with the EPSDT Physician Guidance Workgroup to implement a fluoride varnish training protocol including billing for the procedure
Coordination for training Passport to Health medical providers to conduct oral health screenings as part EPSDT well-child exams. This will also include dissemination of Bright Futures in Practice: Oral Health Guide for anticipatory guidance along with facts about Early Childhood Caries and the importance of good oral health for women to reduce adverse birth outcomes.
In the 2005 legislative session, DPHHS received tobacco funds for the Medicaid Dental Program. Medicaid will use these funds for projects to raise access to dental care including increased dental fees as of July 1, 2005.
Montana is exploring several new ideas to address the access issue; one is the "Rent A Practice" for a day. This idea is to increase the number of Medicaid patients a provider is seeing in a low access area by paying a lump sum in addition to the regular fee-for-service reimbursement for an amount of new Medicaid clients.
The dental program is also requesting a fund increase from the Department's budget planning process for the 2005 Montana Legislative session for dental fees or to pay providers incentive money for serving a higher number of clients.

c. Plan for the Coming Year

Montana is continuing to explore several new ideas to address the access issue; one is the "Rent A Practice" for a day. This idea is to increase the number of Medicaid patients a provider is seeing in a low access area by paying a lump sum in addition to the regular fee-for-service reimbursement for an amount of new Medicaid clients.
Attendance at the 2006 National Oral Health Conference to gain knowledge and participate in networking opportunities.
Ongoing participation as a member of the Montana Oral Health Coalition.
Continue ongoing collaboration with MDA and the Oral Health Consultant.
Pursue avenues to increase participation of dental providers.

State Performance Measure 9: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15%	81%	81	81	82
Annual Indicator	17.8	81.8	80.3	80.5	80.7

Numerator	1935	8849	8746	9077	9183
Denominator	10862	10814	10886	11276	11378
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	84	85	86	85

Notes - 2002

/2004/ In 2001 we changed the reporting requirement to reflect the percent of women who abstained from tobacco use instead of reporting the percent who used tobacco. //2004//

a. Last Year's Accomplishments

2005/ Provided smoking cessation segment at the March 2004 local FICMR coordinators' meeting. A smoking cessation breakout called "Smaller, Hyperactive Babies that Cry" was presented at the Spring Public Health Meeting in May, 2004. Expectant mothers in the Safe Sleep for Baby program were asked to sign a "nosmoking contract" when receiving baby cribs. One mother out of 16 refused to sign or take a crib, but the rest made the written commitment. Funding for Public Health Home Visiting services were issued to 14 counties and 2 reservations. Smoking cessation is an integral part of Home Visiting services to pregnant and post-partum mothers. A preliminary planning meeting was held with the Montana Tobacco Use Prevention Program to discuss collaboration on reduction of smoking during pregnancy.//2005//
Supported March of Dimes "Walk America" Prematurity Prevention campaign by providing information in the workplace as well as to local FICMR coordinators.
June 2004: Hired a state Public Health Home Visiting and Perinatal Substance Abuse Prevention Consultant.
Initiated a work group of Public Health Home Visitors to revise the identification criteria high risk for High Risk Pregnant women to comply with current best practice standards and to identify a screening tool for alcohol and tobacco use.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Reissue an RFP to continue to work toward the PHHV objectives including smoking cessation				**X**
2. Provide training opportunities for PHHV sites focused on tobacco use in pregnancy				**X**
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/ The major thrust for Smoking Cessation/Prevention activities for the coming year will be focused on collaboration with Montana's Tobacco Use Prevention Program to emphasize the connection between smoking and SIDS in babies. This is the second leading killer of infants and continues to claim lives even with the success of the Back to Sleep campaign in reducing the overall rate of SIDS.//2005//

Provided training for 35 public health home visitors on ACOG's domestic violence screening tool, the 4P's alcohol, drug, and tobacco screen, the Life Skills Progression assessment, targeted case management, and data collection.

Facilitated reflective supervision conference calls with public health home visitors to improve intervention skills. Supported March of Dimes "Walk America" Prematurity Prevention campaign by posting educational materials in the workplace and supporting participation by DPHHS employees.

Participated in the Florida AHEC Network teleconference on Helping Pregnant Women Quit Smoking and distributed teleconference information and materials to PHHV sites.

c. Plan for the Coming Year

/2006/ Reissue an RFP to continue to work toward the PHHV objectives including smoking cessation for pregnant and parenting women. Provide acomprehensive training opportunity for PHHV sites focused on tobacco use in pregnancy for one of the two trainings offered annually to the home visitors.//2006//

State Performance Measure 10: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5.7	7.9%	7.7	7.4	7.2
Annual Indicator	7.9	8.4	7.4	6.3	5.7
Numerator	16	17	15	12	11
Denominator	202571	202571	202571	191522	191522
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.0	6.8	6.6	6.4	6.2

Notes - 2003

The data for 2003 are unavailable at this time due to data conversion difficulties from one death records system to another in our Office of Vital Statistics. Data will be updated in next year's MCHBG Report.

UPDATE: Although we now have the incidence of firearm deaths for youth aged 5-19, which is 12, we DO NOT have the denominator of all children aged 5-19 due to delays in receipt of this information from NCHS and the Census Bureau-a format. Therefore, a rate cannot yet be determined and the data remain provisional until next reporting period.

Notes - 2004

The breakdown in 2004 is:

4 deaths 15-17
7 deaths 18-19

The denominator did not change from 2003 because census updates for this breakdown have not been done.

a. Last Year's Accomplishments

BRFSS reported on gun safety and ammunition storage
FICMR coordinator produced a fact sheet and a press release on gun safety and storage based on BRFSS data.
/The FICMR teams have expanded capability to review children's deaths through inclusion of more counties and reservations. The State and local FICMR teams continue to make recommendations for death prevention at the local level. Some local FICMR teams distributed gun locks at local health fairs.//2005//

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with state FICMR team to gather and monitor data and identify possible prevention strategies for gun safety practices.			X	X
2. Promote gun safety and storage awareness via press release and work with local FICMR teams to disseminate firearm safety pamphlets to gun merchants in their communities			X	X
3. Ongoing continued support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools. Gun safety and safe storage of firearms is routinely included in education provided in hom			X	
4. Suicide prevention programs at the state and local level are supported by provision of available brochures and other materials			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

/2005/ Efforts have continued to recruit physicians into the educational process for alerting parents to the necessity of focusing on gun use and storage safety in the home.
Outreach efforts have been made with firearm retailers to provide them with information for consumers about child and gun safety. Collaboration has been explored with Healthy

Child Care Montana and the Child Care Licensing Bureau to incorporate firearm safety in child care settings.112005/

c. Plan for the Coming Year

/2006/ Continue to work with state FICMR team to gather and monitor data and identify possible prevention strategies for gun safety practices.
Promote gun safety and storage awareness via press release and work with local FICMR teams to disseminate firearm safety pamphlets to gun merchants in their communities.
Ongoing continued support for gun safety and awareness classes for youth provided by Fish Wildlife and Parks, 4-H, local public health departments and schools. Gun safety and safe storage of firearms is routinely included in education provided in home visits to high-risk pregnant women and high-risk children.
Suicide prevention programs at the state and local level are supported by provision of available brochures and other materials.

E. OTHER PROGRAM ACTIVITIES

Although mentioned elsewhere in this document, the importance of continuing to develop and refine the public health system and its capacity to support the delivery of the core functions and essential services of public health is worth emphasizing. Due to the rural/frontier nature of much of the state, we depend upon a public health workforce that is overburdened and under funded. In order to maximize the health of the public, and specifically the health of the MCH population, it is important that state level efforts continue to focus on supporting linkages and encouraging efficient delivery of services. A focus on population-based services is also key, with MCH continuing to struggle with its perceived role as a safety net provider of services otherwise not available or funded. The efforts of the Public Health Improvement Bureau and the public health informatics section will continue to help educate and support the workforce, and to improve and streamline reporting in order to decrease the burden on local contractors.

REviewer questions asked for an examination of the low birth weight (LBW) incidence in Montana. A review of the existing data revealed that the appears to be a trend in the incidence of LBW births in Montana. Low birth weight, defined as births less than 2500 grams, is a standard indicator of perinatal health at both the state and federal levels. In response to this concern, a low birth weight trend analysis was performed on aggregate state data for the years 1995 to 2004, stratified by year and race. Using the Cochran-Armitage test for trend for the years in question regardless of race, there appeared to be a significant positive linear trend for the occurrence of low birth weight events in the state. Further investigation into the trend revealed though Native American populations were 16% more likely to have a low birth weight baby than Caucasian populations, however, they were not the cause of the positive linear trend, with noticeable highs and lows apparent for multiple years. The Caucasian population's variability over time was the significant cause of the positive linear trend seen in the analysis, rising approximately 30% since 1995.

In addition, strategic planing will be a focus during the remainder of 2005 and 2006. Further prioritization of health needs will occur using the priorities identified by stakeholders throughout the state and the involvement of FCHB Advisory Council Members and staff.

F. TECHNICAL ASSISTANCE

Technical assistance needs identified to date include:

1. Strategic planning for MCH - As discussed elsewhere in this application, Montana will go through a strategic planning process in FFY 06, informed by the completed needs assessment. Montana's

present FCHB Strategic plan goes through 2005. Consultation on process, direction and incorporation of federal requirements is requested. Holly Grason is the requested consultant.

2. Adolescent health system development - This effort will assist with development of Montana and/or regional and national adolescent health resources and services. AMCHP is a potential contractor for services.

3. Investigate mechanisms to access hospital and insurance record information for data use without statutory authority - Montana does not have legislative authority requiring hospital discharge reporting. Some HSCI require access to that data. No contractor identified to date.

4. CSHCN on performance measurement. - This TA will assist the program to establish measurement criteria and tools for the CSHCN PMs. We are interested in consultation that will allow us to develop Montana specific monitoring tools, and help to develop the accompanying methodology for using those tools. No contractor identified to date.

5. Perinatal depression - the impact of depression on the perinatal poplation is of great concern. Mechanisms to collect population based information, in order to better assess need and plan intervention strategies are needed. No contractor identified to date.

6. Montana specific Adolescent Health Needs Assessment - This request is related to #2 above, but specific to Montana. This request is for TA to enhance and expand information regarding the adolescent population in the state using the System Capacity Tool for the Adolescent Health Program. Suggested consultant would be Kristin Teipel (Project Coordinator, State Adolescent Health Resource Center, Konopka Institute for Best Practices in Adolescent Health, University of Minnesota, Minneapolis, Minnesota).

V. BUDGET NARRATIVE

A. EXPENDITURES

Montana depends upon its local partners for provision of MCH services to the population. 42% of the MCHBG is distributed to local county contractors under MCH services contract. Local match continues to be well beyond the reuired level, with local match of about $3.6 million, instead of the approximately $825,000 which would be required under the present contract. Montana does not have enough state general fund to pull down the federal funding, with a total of slightly over $1 million, instead of the $1.9 million needed.

Local match continues to increase, partly due to improved reporting expectations and compliance, and due to the response of locals to the request for accurate reporting which will allow better understanding of true costs of MCH services. For the first time in 2004, we were able to capture and report the program income.

Please see attachment for charts depicting trends.

Form 3 - Federal funding stayed about the same from 2001 through 2004 - federal decreases in 2005 and potentially 2006 will result in a drop in the federal level. The state funding also continues to go down slightly. Efforts to increase funding are anticipated for the 2007 session, depending upon fiscal picture. Local funding has had the most increase, albeit variable.

Form 4 - Children continue to be the primary target of services in the state. Screening programs, including school health services would be included in those costs. Many county health departments continue to assume school health services as part of their responsibilities, often without funding from the school district or reimbursement from insurance coverage's.The increase in infant and pregnant women expenditures may be in part attributed to the program income, much of which is for targeted case management for high risk pregnant women and infants. Variations between budgeted and expended amounts continue to vary by as much as 40% in some categories (pregnant women and others).

Form 5 - Direct expenditures reported by the counties continue to be high. This is in part due to definition and reporting issues. Large variations in expenditures by level of the pyramid continue. While definition issues continue to confound, a large percent of funding continues to support direct health care.

B. BUDGET

The proposed budget for FFY 20046as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $829,709

Budget includes the CSHS budget of $764,000 plus $65,000 of cunty MCHBG which they report expending on the CSHCN population.

Title V Administrative Costs $224,404

Includes state indirects of $176,633 plus anticipated local of $47,77100,000. Administrative rule allows counties to use up to 10% of their award for administrative costs. The state admin costs are

increased by approximately $40,000, due in part to conversion of the BC position for "direct pay" to cost allocation.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $1,085,637

Budget includes public health home visiting general funds ($550,000) and funds to support the voluntary genetics program (apprximately $530,00).

Local MCH Funds $3,598,977

Local contractors continue to overmatch their contracted $1.1 million.

Program Income $791,235

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $8,023,781

Other Federal Funds $18,334,262

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.